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ABSTRACT

This double issue of the journal "Report" focuses on the collaboration among seven social service systems that support and serve children and families. Each of the sections discusses one of the seven systems, presents an overview essay, and profiles programs that execute the service. The first section, on education, emphasizes linkages between schools, communities, and families to ensure educational success. Section 2 is concerned with the child welfare system and its support for foster families providing physical and emotional safety for children. The focus of Section 3 is the health care system and its scope beyond traditional clinical care. Youth development is discussed in Section 4, as a parallel movement to family support. The program profiles deal specifically with low-income and minority families in African-American neighborhoods. Section 5 focuses on supporting people with disabilities through centers and home visiting programs. Section 6 is concerned with the welfare system and using a new approach of combining employment services with family services. The last section focuses on the child mental health system, which is concerned with services for children and adolescents with emotional and mental disturbances. (BAC)

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Report

SPRING/SUMMER 1994 Volume 13, Numbers 1 & II
—DOUBLE ISSUE—

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BUILDING BRIDGES: Supporting Families Across Service Systems

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FAMILY RESOURCE COALITION

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REPORT
Editor, KATHY GOETZ
Art Director, LYNN PEARSON
Reporter, JACQUELINE LALLEY
Copy Editor, JACQUELINE LALLEY
Cover Illustration, CHRISTOPHER PALMER
Printer, BOOKLET PUBLISHING, INC.

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BUILDING BRIDGES:
Supporting Families Across Service Systems

by Charles Bruner

There is growing recognition that different systems serving children and families need to work with one another—to collaborate in meeting the needs of families.

The reasons are reflected in what front-line workers see on a daily basis. Teachers see that children bring more than educational needs into the classroom. Health practitioners know that pregnant women bring more than medical needs into the health clinic. Professionals in job training see that families bring more than employment needs into the welfare office.

Moreover, unless these other needs are addressed, teachers know that it will be difficult for children to learn well. Health practitioners know that the prenatal care they provide will not necessarily result in a healthy birth. Job trainers realize that many of their graduates will experience difficulty in establishing stable, long-term attachment to the workforce.

The calls for collaboration, school-linked services, and service integration reflect this growing recognition. Further, reformers increasingly are turning to family resource centers and family support programs, which, in two ways, can be a critical connecting link, or bridge, for collaborations that lead to family success.

The first way that family resource centers and family support programs enter into discussions of collaboration is programmatic. Most literature on collaboration and service integration views family resource centers and family support programs as filling a missing service niche at the prevention and early intervention end of the service continuum.

Collaboration, in this case, assures cross-system referral and follow-up. There is someone providing "case management" or "care coordination" so that families experience a more "seamless" system of services and supports that are coherent and integrated rather than conflicting and fragmented. When professionals in different service systems collaborate, all are better informed of each others' involvement with families and are more capable of integrating their workplans. They have greater familiarity with other services for families available in their community and are more successful in making referrals for additional supports.

Programmatically, family resource centers and family support programs are also seen as bridges between the professional service systems and voluntary support networks—family, friends, churches, community associations. Public institutions and agencies refer families to family resource centers and family support programs; these centers and programs bridge for families the public and the private, the therapeutic and the normative, the specialized and the general, the professional and the voluntary, even the church and the state.

The second way that family resource centers and family support programs enter into collaborative strategies is philosophic. As well as being programs and providing services, family resource centers and family support programs represent a service philosophy based upon specific values: building upon strengths, partnering with families, individually tailoring supports, being holistic, valuing diversity, focusing upon individual growth and development in the context of the family, and viewing the family in the context of the neighborhood and community. Those collaborating with family resource centers and family support programs must articulate the role that family support principles should play in working with families within, as well as across, service systems. Collaboration between family resource centers and family support programs and other service systems cannot truly exist unless these other systems reflect the same undergirding values.

Moreover, the work that family resource centers and support programs do to empower families can easily be undermined when families experience other service systems that are deficit-oriented, dominating, impersonal, fragmented, arbitrary, and individual-based rather than family-focused. While the mission statements from most public service systems do not embrace such

characteristics, too many families see these systems in this light.

Unless the education, child welfare, mental health, public welfare, disability, youth services, and health care systems better incorporate family support principles into their professional practices, family resource centers and family support programs will be fighting an uphill battle. At best, they will serve as temporary oases from the mainstream institutional services and supports with which families (particularly socially isolated and vulnerable families) must contend.

This issue of *FRC Report* provides evidence that new programs and service strategies incorporating family support values are emerging within public service systems. As family resource centers and family support programs have grown over the last two decades reforms also have been underway to reshape service philosophies within each of these systems.

It is important that family support practitioners and advocates build bridges to these reform efforts because:

1. Public service systems are developing effective practices that deserve to be applied within family resource centers and family support programs, including: effective outreach strategies, assessment techniques, evaluation tools, and financing mechanisms.

2. At the local level, the individual programs and practitioners that incorporate family support principles into their work are natural collaborative partners with family resource centers and family support programs. Identifying other services in their communities that adhere to family support principles helps family resource centers and family support programs operate most effectively.

3. The people behind these reform efforts represent potential allies for promoting policy reforms and undertaking public education efforts to broaden support for family resource centers and family support programs. They are needed as partners in the process of defining the appropriate role of their programs in changing the way public systems respond to families and neighborhoods.

4. If public policies, practices, and programs are to succeed with children and families with whom they currently fail, mainstream public institutions—schools, child welfare agencies, public welfare departments, mental health services, health care systems, and disability services—must be transformed. It is within these systems—and not within family resource centers and family support programs—that the bulk of public resources will be spent on, for, to, or with families. If family support practitioners and advocates recognize the need for these larger reforms, the family support movement can be a catalytic force and ally in such transformation.

The first step in the process of building these alliances is understanding the reforms in practices already underway within public service systems.

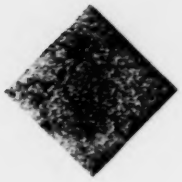
The first step in the process of building these alliances is understanding the reforms in practices already underway within public service systems. The articles that follow highlight some of the best examples of family support values being operationalized within different professional practices. They are arranged under the professional service disciplines of education, child welfare, health care, youth services, disability, public welfare, and mental health. The programs described within these disciplines are truly innovative, cutting-edge efforts. They represent the potential for these mainstream service systems to change; they do not reflect common practice within these fields. Each section's overview essay offers some of the most advanced thinking on transforming the professional system to better meet family needs. Program profiles illustrate family supportive approaches in action.

Taken together, these articles represent a first effort to describe the connection between family support values and larger reform agendas within and across other service systems.

As these articles show, the changes that are needed are profound. If larger reforms are to succeed, there must be changes in the manner in which teachers teach, child welfare services protect children from harm, and mental health professionals work with families. Welfare reform efforts must not only help parents enter the workforce, but must also ensure that their children live in safe home environments and start school ready to learn. Parents of children with disabilities must be recognized as experts on their children's needs by the professionals who serve them.

While these changes are profound, they also are based upon sound underlying principles of effective practice. They ultimately will enable families to succeed, regardless of the service systems they use. While the first phase of the family support movement may have been to build a new, and necessary, programmatic base, the next phase is to assure that all systems serving children and families reflect the values responsible for family support's success.

Charles Bruner, Ph.D., is director of the Child and Family Policy Center, a former Iowa legislator, and a member of the board of directors of the Family Resource Coalition.



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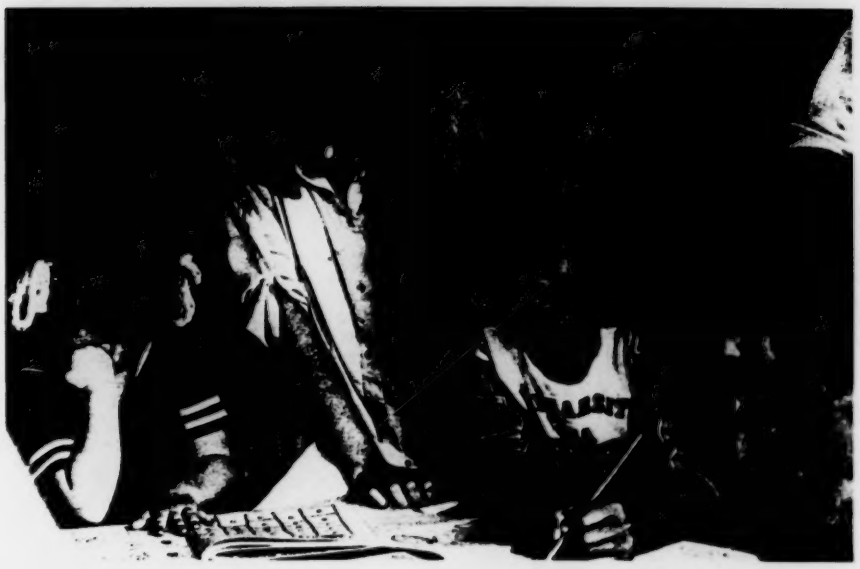
OVERVIEW

Assuring Success in Education through Supporting Communities and Families

by Bill Shepardson



Educators are coming to realize that if all children and youth are to develop the skills, competencies, and dispositions they need to succeed in life, our investment in their education must transcend the school's traditional focus on cognitive development. Notions of "student success" are being broadened to encompass young people's continuing intellectual, physical, emotional, and social development. In response, educators are working with families and communities to build supportive and respectful environments that nurture young people and bolster the development of healthy attitudes and actions. The overall goal is to make sure that all children and youth are healthy, safe, well educated, and happy; and that over time they are prepared to engage in productive employment, lead healthful lifestyles, be knowledgeable and contributing citizens, form strong families, and fulfill adult responsibilities.

Against this backdrop, educators are beginning to think more systemically about how schools can effectively contribute to achieving these challenging goals. This systemic approach to education reform requires that education policies and practices share a clear vision of what students should know and should be able to do as a result of education.

Families, students, and other segments of the community must be involved in developing visions and standards for the education system and in the education process itself. The services students and their families need must be reliably and effectively provided, so that students are able to learn. In short, a restructured education system must help to create the supportive environments young people need through collaborative efforts among

families, schools, and other community agencies.

The Challenge for Schools and Communities

The eight National Education Goals that were recently codified in the Goals 2000 Educate America Act set ambitious standards that will only be reached through concerted work by communities, schools, families, and students. It is increasingly clear that communities that are able to muster a broad range of supports and services in a coherent manner are more likely to meet those goals than those that are not. In communities that are serious about working jointly on behalf of children and families, schools are reassessing their policies and practices to make sure they are aligned with community efforts to support families and to provide diverse developmental opportunities for kids.

However, this does not mean that schools are trying to become comprehensive service providers. Schools can change internally in many ways and can reach out to other institutions without single-handedly taking responsibility for ensuring the well-being of all children and families. Schools can—and in many cases already do—contribute to developing the skills and competencies young people need for sustained success in our society. Health classes and physical education, for instance, help students develop the knowledge, attitudes, and behavior needed for healthy lifestyles. Civics classes and opportunities to serve the community encourage active citizenship. Cooperative learning and other group activities foster interpersonal skills and hone students' abilities to develop friendships, to work collegially, to communicate, and to negotiate. Many schools are preparing students for the world of work by providing an early and ongoing orientation to vocational options that includes discussions on how to prepare for specific careers. And in some communities, these opportunities are no longer considered secondary to the school's primary goal of fostering academic achievement. Instead they are seen as the school's contribution to a community-wide effort to foster the overall development of children.

In addition to taking a critical look at the nature of schooling, educators are examining the extent to which schools can be a point of contact for children and families in need of support and services that can be provided by other agencies and organizations. Playing a role in ensuring the availability of family support programs, parenting education, prenatal care, and health services increases the likelihood that children come to school ready to learn. Joining with employers to provide expanded opportunities for work-based learning programs gives added currency to traditional academic experiences.

Schools are well-established institutions with ties to local neighborhoods and communities, municipal structures, and state government. However, schools should not necessarily govern or administer these community-based efforts. In fact, it would be a mistake to assign responsibility for the entire range of children's and family services to school systems that already have their hands full with their basic mission.

School-linked or Community-based: A False Dichotomy

The notions of school-linked and community-based support systems do not inherently conflict with each other. Schools are an essential (but only one) ingredient in the mix of agencies, organizations, and citizen groups that must contribute expertise and resources to better support children and families. Their near universal access to students and families is one advantage of their substantial involvement in such efforts. Where school facilities have been underused, they can be employed to meet other community needs. Providing certain services to all students and their families at or near the school site—day care for teen parents, for example—can help keep young people in school. It also can lessen the stigma associated with seeking assistance, thereby increasing access to and use of prevention and support services. Perhaps most importantly, linking schools with family support and other family-centered programs can positively affect the ways in which school personnel interact with families.

By joining the resources of the school with those of other groups at or near the school site, the community expands both the number and the nature of supportive services and developmental opportunities that are easily available to families and children. Family support programs and social service agencies possess the talent and resources to give assistance that schools are not equipped to provide. Community agencies that support youth development—clubs, recreation and sports organizations, and religious organizations—complement schools not only in services and activities, but also in structure and function. Young people attend voluntarily; they choose activities and progress at their own pace. Private- and corporate-sector involvement can bring increased resources and add greater visibility and legitimacy to efforts to support children and their families.

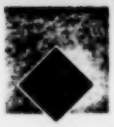
If care is taken in building school/community relationships, school-linked efforts will not result in schools interfering with or duplicating the efforts of other community groups. All community institutions and agencies serving children and their families must engage in strategic, long-term planning to ensure that no institution's agenda or organizational needs dominate collaborative efforts. True collaboration requires sharing resources, authority, and leadership to achieve goals that would be unattainable without collective action.

Strategies for Change

A great deal of experimentation in the area of school/community collaboration has begun. Still, much work remains if collaboration among schools, families, and communities is to enhance our investment in children's sustained development and success. Schools and communities that are committed to improving the lives and opportunities of children should consider embracing the following strategies.

- **Changes in the Nature of Schooling**

Schools should reevaluate their policies and programs and should change them where appropriate to reinforce the goals of supporting families and increasing developmental opportunities for children. For instance, the availability of health services should be accompanied by a comprehensive K-12 health curriculum that provides students with the knowledge and skills they need to develop health-enhancing behaviors.



PROFILE

"But *These* Parents Just Aren't Interested": The League of Schools Reaching Out Challenges an Old Assumption

by Don Davies

The League of Schools Reaching Out is a network of schools that began in spring 1990 and now includes more than 90 schools in six countries—the United States, Australia, Chile, the Czech Republic, Portugal, and Spain. The aim of the League is to increase the academic and social success of all children—especially those who are underserved—through family-community-school collaboration.

The League grew out of a question: what makes "hard-to-reach" parents (long regarded as a cause of educational failure in low-income communities) hard to reach? Many felt that these parents were indifferent to their children's education. Why else would they fail to attend conferences with teachers or to oversee their children's homework? A 1988 study came up with a surprising answer: it wasn't parents who were hard for schools to reach, but schools that were hard for parents to reach.

The study, carried out in Liverpool, Lisbon, and Boston, also revealed that the U.S. had no monopoly on negative views of low-income people, whose presumed indifference to their children's academic success is widely—perhaps universally—regarded as one of the reasons poor children fail in school. The study showed, however, that low-income parents were every bit as interested in having their children succeed in school as middle-class parents were. Although great numbers of low-income parents stayed away from schools, the study showed it wasn't because they didn't care. It was because they saw no role for themselves. Many had fared poorly in school themselves and felt they had little to offer academically, were intimidated by administrators and teachers, or found the schools simply unapproachable and hard to reach.

This study resulted in a pilot project called "Schools Reaching Out" in which ideas for bridging the gulf between parents and school were tested in one school in Boston and one in New York City. Three ideas succeeded so remarkably that they became the foundation of today's expanded and rapidly growing League of Schools Reaching Out.

One idea was to set up a parent center at the school. Many urban schools today are like armed camps, so concerned with security that doors are locked to the outside world, volunteer guards patrol the hallways and accost all unfamiliar adults, and armed security officers sit at desks inside the front door. Vivian Johnson, a Boston University professor conducting research on parent centers for the Center on Families, Community, Schools, and Children's Learning, knows of one parent who was so nervous about entering her son's school that she would meet with school personnel only outside, on the street corner.

What makes hard-to-reach parents hard to reach?

The parent center, which often consists of little more than a room, a few tables and chairs, a coffee pot, and a telephone, is a simple but highly effective way of communicating the idea that parents are welcome at school. At one school in Boston, the parent center is one end of the library, and operates only when classes are not meeting there. Nevertheless, it works. Parents have a place of their own, and with it both a symbolic and a real presence in their children's school. Parent centers have sprung up in more than half of the League schools. Staffed by a paid or volunteer parent, each center is a place to drop by and chat, to get information about school activities, to meet with teachers, to get involved in volunteer projects in the classroom, to participate in distributing food or clothing to people in the community, to find out about employment opportunities, to take GED or ESL classes, to watch a video on child-rearing, to get a social service referral, or to gather with other parents, teachers, and administrators for a celebratory breakfast on the first day of school.

Another important idea tested in the original pilot was a home visiting program. Students' parents visit other students' parents—not to offer advice on "moral improvement" like the "friendly visitors" of 19th century charitable organizations, but to bring news and information, talk about problems, offer instructional materials for helping with homework, and become links between parents and schools by taking parents' concerns back to teachers and administrators. At the O'Hearn School in Boston the program began with just four mothers, who went through a training course and then began calling on other parents. Today League schools with home visiting programs are supplementing their outreach with automatic telephone calling, phone trees, newsletters in several languages, and broadcasting school announcements and special programming on cable television networks and ethnic radio stations.

The third idea generated by the pilot Schools Reaching Out may in the long run have the most impact on schools. Called at first "teacher action research," it was an effort to engage teachers in the process of school reform as actors rather than as weary recipients of ill-fitting reforms devised at remote district headquarters. A team of teachers received small stipends to interview other faculty members and to devise an "intervention"—a program or project aimed at alleviating a certain problem. The team then implemented the proposed solution (drawing on Chapter 1 or similar funding sources), studied its progress by gathering data on its effects, and recommended correctives. This course of action sounds simple, but in fact is diametrically opposed to the normal order of business in any bureaucracy, in which change, if it is to happen at all, is likely to happen only from the top down. Teacher action research, by contrast, puts teachers into the role of researchers and offers them the opportunity to transform their personal experience of the everyday realities of school into plans for change. Today in League schools, parents have been added to the equation, and are forming teams with teachers and administrators to devise, study, evaluate, and alter projects to answer the needs of their own

Continued on next page

particular schools in their own particular ways.

The League of Schools Reaching Out offers technical assistance to member schools and encourages them to develop parent centers, home visiting programs, and parent-teacher action research. It differs from other school reform organizations in that it does not require these or any other specific activities for membership. Instead the League encourages schools to develop their own collaborations and is more concerned with attracting attention to successes than with prescribing procedures. It does require its members to commit to the education of all children, including those who in the conventional wisdom are destined not to "make it" because of who they are or where they live; and to commit to the creation of partnerships between school and community, including not only parents, but also organizations, agencies, and businesses.

Why are the League and similar efforts likely to be any more successful than the many reforms of the past? This is a question that awakens this and other long-laboring reformers late at night. But amid sinking test scores and rising violence, there is cause for hope in efforts like the League. The League is working. The involvement of parents is making a difference in schools—in what some call the "worst" schools. "My broken down piece of building," the principal of an inner-city school in Ohio calls her school, shaking her head and smiling. The paint is peeling off the walls and the threat of drive-by shootings keeps children indoors at recess time, but her school has adopted the idea of community involvement as the foundation of its pedagogy, and the place is crowded with community people—senior citizens, boy scouts, church groups, and business people, who are helping the community's children learn far more than the old school lessons.

And perhaps more fundamentally, the existence of reform efforts such as the League reflects the dawning of an important realization on the part of American society. A corollary to the now popular proverb that it "takes a whole village to raise a child" is the unhappy truth that every child who fails is, in fact, a failure of the whole village. If this profound conviction takes hold of the American psyche, as it shows some signs of doing, it will change much more than schooling.

Don Davies, former deputy commissioner, U.S. Office of Education, is the founder of the Institute for Responsive Education and co-director of the Center on Families, Communities, Schools, and Children's Learning.

For information contact Etta Green Johnson, director, The League of Schools Reaching Out, at the Institute for Responsive Education, 605 Commonwealth Avenue, Boston, MA 02215.

Health services and health education should be reinforced by a healthy school environment, which includes a psychological climate conducive to learning and safe physical surroundings. Another curriculum change might involve community-service learning opportunities, which give students experiential learning opportunities while transforming them into community resources. Another nchange involves connecting school and employment. Schools must provide curricula, resources, and learning places that prepare students for employment, as well as increase their accountability for the level of students' readiness for work.

• Interaction with Families

Schools must be able to work in partnership with families in a supportive, culturally relevant manner that builds on families' strengths. If school-linked efforts to support families are to be effective, schools and other participating agencies must look critically at the assumptions that underlie the way they interact with families. It is not enough to simply recognize cultural and linguistic diversity; schools must accommodate and respond to the values and cultures of the families they serve. Staff attitudes and expectations may need to change, to create school environments in which each family feels that its contribution to its children's education is valued.

• Youth Development Opportunities

Diverse opportunities to develop competencies that complement and reinforce academic competencies must be available to all youth. The purpose of providing these opportunities must go beyond solving or preventing problems—such as school failure, substance abuse, and teen pregnancy—and must encourage youth to develop positive behaviors and abilities, such as community service, regular physical activity, leadership, and creating art. Schools must offer students these developmental opportunities, including chances to take part in music, sports, art, and drama; to be leaders in the school community; to develop problem-solving, communication, conflict-resolution, and decision-making skills in the classroom; and to seek guidance from caring adults. Educators must also join with parents and other members of the community to provide these experiences outside the school.

• Community-wide, Results-oriented Accountability

To attain the results we desire for youth, such as high-level learning and other competencies crucial for success in American society, we need new systems of accountability. Educators are making great strides in developing accountability systems to ensure that all children are achieving academic competence. However, progress needs to be made toward measuring skills and competencies in other critical areas. Currently we cannot easily track whether our children are becoming good citizens, adopting behaviors that will ensure future health, or developing an understanding of the value and function of work in our society. Without good indicators of progress, accountability remains elusive. Ideally, every community should have a system for holding schools, human service agencies, and other community organizations accountable for making sure that young people achieve the positive results.

• Creative Strategies for Financing Children's and Family Services

We must develop financing strategies that promote effective services and supports for families and diverse developmental opportunities for all children. This will entail redeploying existing funding to meet the goals of a school-linked, community-based strategy. Public dollars must be employed to prevent problems before they happen as well as to provide developmental opportunities for children before they have earned the label "at risk." Funds must also be freed up for use as "glue" money for planning and administering comprehensive support and development programs. Efforts to use federal funding streams to refinance services currently paid for with state and local funds must be pursued. Financing strategies must be reviewed to assess potential increases in funding, consistency with program goals, and anticipated increases in administrative burden. Any money saved—by drawing down federal funds, eliminating duplication of

PROFILE

Changing the Way Schools Do Business:

"The Comer Model" and Accelerated Schools

by Carolyn Ash

Four years ago, at Jefferson Elementary School in Chicago, school decisions were made by the principal or a committee appointed by the principal. There were conflicts and confrontations between staff and between parents and staff. Students weren't achieving their potential.

Today, the principal, teachers, other school staff such as custodians and administrative staff, parents, and other community members work together to reach consensus around decisions that affect children. Many parents have gone back to school or have become employed. More students are performing at or above national norms; more are actually getting a year's educational growth after a year of schooling.

What accounts for these changes? Approximately four years ago, Jefferson adopted the educational model of the Accelerated Schools Project at Stanford University. A year later, the school included the model of the School Development Program developed by James Comer at Yale University. Becoming an Accelerated/Comer school has turned Jefferson around.

What are Accelerated Schools?

In the Accelerated Schools program, developed in 1986 by Stanford University professor Henry Levin, the goal is for all students to achieve at or above grade-level by the end of sixth grade. The program is based on three key principles:

1. a schoolwide **unity of purpose** through which teachers, students, and parents agree on common goals

2. **empowerment** through school-site decision-making and responsibility

3. instructional strategies that **build on the strengths** of students, teachers, administrators, other school staff, parents, and the community

Accelerated Schools are characterized by school-based governance; pupil and school assessment ("taking stock," as some school personnel call it); an emphasis on health and nutrition; a relevant curriculum that stresses language-based and higher-order thinking skills, including analysis and problem-solving; innovative instructional strategies, such as mixed-ability groupings, active learning, peer tutoring, and cooperative learning; parent involvement and use of community resources; and extended day sessions.

While all Accelerated Schools include these curricular, instructional, and organizational practices and principles, each school develops a plan tailored to its own vision. The first step to becoming an Accelerated School is creating a steering committee composed of the principal, teachers, and aides. This steering committee, then, organizes additional committees to address the priority issues for that school. In collaboration with the district, the school develops a school improvement plan.

What is the Comer Model?

"The Comer model" is shorthand for the Yale Child Study Center's School Development Program (SDP), directed by Dr. James Comer. Established in 1968 in two elementary schools, the SDP model began as a collaborative effort between the Yale University Child Study Center and the New Haven Public Schools. "The two schools involved were the lowest achieving in the city, had poor attendance, and had serious relationship problems among students, staff, and parents."[1]

The Comer model took shape in response to these conditions. Its four main components are:

1. a **mental health team**, consisting of a social worker, psychologist, and special education teacher, which works to identify and prevent behavioral problems and to connect schools with community resources

2. a **governance and management team**, consisting of the principal, a member of the mental health team, a teacher, students (in middle and high school), and selected parents, which plans strategies, gathers resources, and implements interventions

3. the **parents' program**, in which parents are encouraged to work as part-time aides in the classroom, as members of the governance group, and as participants in schoolwide academic and social events

4. **curriculum and staff development**, which support the physical, moral, social, psychological, speech, language, cognitive, and intellectual growth of all students

The program aims to help children bridge the gap between the attitudes, values, and behaviors they experience at home and the ones they experience at school. In Comer schools, parents, teachers, and other school staff work toward common objectives and create compatible environments for children. Parents, school staff, community members, and central administrators are all responsible and accountable for the implementation of the program.

After approximately 20 years, more than 300 schools in 18 states and the District of Columbia have adopted the Comer, or SDP, model. "Numerous schools using the SDP model report statistically significant gains in the targeted academic and social areas—language arts, reading, mathematics, attendance, and school behavior—compared to similar schools not using the model. Several SDP schools have made spectacular academic gains and have received national attention."[2]

Jefferson Elementary School Principal Harold Miller believes that people are more likely to "buy into" something if they have input in it. Jefferson has used the Comer and Accelerated Schools models to transform itself into a responsive learning environment that includes families and community members as partners in the educational process.

The Comer and Accelerated Schools models are examples of family-supportive approaches to reforming the system in which children are educated—altering the way that teachers teach, administrators administrate, and parents parent. Incorporating their principles and practices changes the way that schools do business and benefits children, their families, their schools, and their communities.

Carolyn Ash is a program development associate at the National Resource Center for Family Support Programs at the Family Resource Coalition.

[1] Comer, J. P. "A Brief History and Summary of the School Development Program: 1993–94." (unpublished)

[2] Ibid.

Author's note:
Special thanks to Harold Miller and Yolanda Weaver, at Jefferson Elementary School, for graciously agreeing to be interviewed for this article.

PROFILE

Watts/Jordan School-based Health Clinic:

Promoting Health and Preventing Violence in Los Angeles

by Bobby E. Sheffield

Like many inner-city communities, Watts and South Gate, in Los Angeles, have been plagued by a high incidence of violence in the home, in schools, and on the streets. Sexually transmitted diseases (including AIDS) and other illnesses and pressure to abuse drugs and alcohol pose additional dangers. Many teens become pregnant, and pressures to drop out of school and to join gangs are high. In short, teenagers have a hard time staying safe and healthy, much less succeeding in school and in life.

In 1985, parents, educators, and youth came up with a way of curbing the violence and poor health that plagued the teen community: they went to school. A combination of violence prevention programs and physical and mental health services have been available on site since 1987 at the Watts/Jordan School-Based Clinic at Jordan High School. The clinic became the first of three to open on the campus of a high school in the Los Angeles Unified School District, and is a project of the school district's board of education and the Watts Health Foundation, Inc. It serves a student body that is 70 percent Latino and 30 percent African American.

A Full Range of Physical and Mental Health Services

Some of the health and mental health services available at the clinic year-round include general medical care such as treatment for common illnesses and minor injuries; referral and follow-up care for serious illnesses and emergencies; sports and employment physicals; immunizations; consultation, referral, and follow-up for pregnancy and chronic disease and disorders; health education and preventive services regarding pregnancy and sexually transmitted diseases; and counseling for mental issues and other concerns facing at-risk youth. Follow-up home visits are an important part of ensuring that full recovery is made or that counseling has been effective.[1] In order to increase the support students receive, clinic staff train teachers on gang violence, drug activity, family conflicts, teen pregnancy, and teen parenting.

Violence Prevention Program

When the clinic was first established, youth at Jordan High School told staff that their number-one problem was violence. Staff then developed and introduced a 10-day violence prevention curriculum and trained teachers to present it to all entering ninth-grade students. During ten 30-minute sessions, students define violence and homicide; identify risk factors of violence; discuss fighting and its consequences, "anatomy," and precursors; explore anger; talk about gang influence; and learn problem-solving alternatives to violence. Students sign an "I Say No to Violence" pledge at the end of the course.

Other components of the violence prevention efforts have included a "Prison Preventers" program, in which inmates visit the school and talk with students; and boys-to-men/girls-to-women seminars, followed by discussion sessions.

During the summer the clinic uses the auditorium as a movie theater for local youth, to continue violence prevention by offering youth positive alternative activities. Summer school students who maintain at least a "C" average also can participate in outings to baseball games, museums, and theme parks.

Whole Community Reaps Benefits

The Watts/Jordan School-Based Health Clinic and its programs are increasing students' chances of academic and general success; while still in high school, some are employed by the clinic as teen advocates and peer counselors and several program participants have gone on to college after graduation. The clinic has proven to be a godsend for parents, because it eliminates the inconvenience of missing work to take their children to the doctor and makes excellent medical care for everything from the common cold and minor infection to serious illnesses available right there on campus.

The Watts/Jordan School-Based Health Clinic has made a real difference in hundreds of lives and has saved more than a few.

In partnership with parents, the clinic is reducing teen pregnancy, discouraging alcohol and drug abuse, helping to prevent the spread of sexually transmitted diseases, and helping youth develop alternatives to violence. Clinic staff and school personnel work as a team, counseling, educating, and preventing many of these ills that plague our society. The clinic is proving that school-based health clinics are not just a critical health care resource, but a critical educational resource that should be a part of every high school curriculum.

Bobby E. Sheffield has served as the director of the Watts Health Foundation's School-Based Services for the past six years. He is a member of Los Angeles and Banning police departments' Youth Gang Services, Los Angeles Police Clergy Council, Riverside Ministers Alliance, and the National Council on Alcohol and Drug Dependency Board of Directors. Mr. Sheffield is pursuing his doctorate from Pacific Western University, and holds a Master's degree in psychology from Loma Linda University. He is pastor of Garden of Gethsemane Church of God in Christ in Los Angeles, California.

For more information about the Watts/Jordan School-Based Health Clinic call the Watts Health Foundation at 213/569-7183.

Notes

[1] Unless the student has been declared an emancipated minor by court order or is married, parental consent is required to access the services, and parents may give permission for the clinic to provide some services and not others. Once parents give their consent, they are not informed of their children's visits to the clinic, but staff encourage youth to talk with their parents about their health concerns.

PROFILE

Building a New School from the Ground Up

Valeska Hinton Early Childhood Education Center
Peoria, Illinois

by Bette Wilson

There is a very popular old African proverb,"It takes a whole village to raise a child." Many people use the phrase; few take it from theory to practice. Investing seven million dollars, the Peoria Public School system in Illinois has done just that. With the guiding philosophy that school is for families and the community, they undertook an extraordinary collaborative planning process which resulted in a state-of-the-art early childhood education center, the Valeska Hinton Early Childhood Education Center for preschool through second-grade children and their families.

A Unique Planning Process

This model school took three years to plan. To ensure a thorough and comprehensive planning process with broad-based, high-quality input, the district's superintendent formed an advisory committee of district administrators; school board members; the public building commissioner; professional early childhood consultants; personnel from other early childhood programs in the city (Head Start, YMCA, Urban League, and day care centers); local businesses; the community college and university; parents; and the architect.

The committee wanted to turn a patchwork of early childhood education programs into a cohesive whole, to share training resources, and to create a vehicle for attacking systemic problems that impair children's development, according to Dr. Judy Harris Helm, professional development coordinator for the center. They used sophisticated concepts to design a new school that could provide high-intensity intervention. "Although these concepts have appeared separately in schools," Helm said,"no other early childhood program to date has combined all of [them] into a high-impact design like this one." Dr. Barbara Bowman and Dr. Lillian Katz, two experts in the field of early childhood education, consulted on the project.

Involving the architect early in the process assured that the space would support the school's mission, programs, staffing patterns, operations, and activities: this early childhood center would not be for children only. Children and teachers, parents and siblings, adult students, visiting teachers, resident and itinerant professionals, community service agencies, visitors, and the Center's support staff—the numerous groups who would be using the building—identified their needs, the architect designed the space to accommodate them.

The Center's planning process continues to be collaborative. Original advisory committee members plus additional parents and community members comprise an advisory task force, and an active parent advisory board meets regularly. New issues, needs, and concerns are continually being raised and addressed.

The Village Concept

The center is organized into four "villages," each with three multi-age pre-primary and two multi-age primary classrooms, as well as a planning office, a conference room, and a full kitchen. All teachers in a village plan together and share responsibility for the achievement of all the village's children. All staff (leadership, custodial, teaching, office, and food service) participate in team-building activities.

Children, including those with special needs, are assigned to a village and stay in that village for four years—two in a pre-primary classroom and two in a primary classroom. All siblings come to the same village; a family may be part of a village for over a decade as siblings come through. To further ensure continuity, the school alternates nine-week teaching periods with three-week vacation periods year-round. Childcare is available during the vacation periods. Health care is provided on-site by a nurse practitioner.

Children eat two meals and snacks in their classrooms family style, and parents are encouraged to join their children for meals. Family support associates, full-time employees of the Center, provide before- and after-school childcare. As one might expect, Hinton classrooms are carefully planned environments, with learning centers and play areas, but Hinton also has designed an environment for parents.

Including Parents

While many schools seek to involve parents in their children's education in order to promote children's learning, the Valeska Hinton Center was intentionally designed to include and support parents as partners in their children's education, in their role as parents, and as individuals. The Center encourages parents' personal and professional development by offering both day and evening GED preparation, Adult Basic Education, literacy classes, and job skills training. Parents may come to the Center with their children on the school bus.

Nutrition, first aid, and parenting classes are also offered. Parents have lockers, a lounge, and a toy-lending library on-site at the Center. A professional development center provides supplies and equipment for preparing instructional materials.

The same family support associates who provide before- and after-school childcare are the principal outreach workers for the Center; encouraging parent involvement and informing parents of what the Center has to offer are major parts of their job. Family support associates also conduct parenting classes as well as home visits.

The Center's Staff

Because hiring, training, and supporting appropriate and high-quality staff is critical to the Hinton Center's success, a team, representing all staff positions, developed job descriptions and hiring criteria (including attitudes and abilities) for the following staff positions:

- principal/director
- professional development coordinator
- family and community liaison coordinator
- teachers

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• associate teachers

• family support associates

All staff are viewed as part of a team and work together to carry out the school's mission. Staff are hired after an interview with staff and parents.

Hinton as a Training Center

Since at-risk children and their families from all over the district travel by bus to attend Hinton, and since children transfer out after second grade, staff work to ensure that their students' success is not eroded later on and to spread the benefits of their collaborative, holistic approach throughout the district. The Center trains all prekindergarten through second-grade teachers to build academic self-confidence, to provide developmentally appropriate instruction, and to utilize parents as partners in education. Teachers come from throughout the city for professional development—to expand their knowledge about the best early childhood education practices and their implications for all grades.

Bette Wilson is former school-linked services coordinator for the National Resource Center for Family Support Programs at the Family Resource Coalition, and is director of multicultural education for the Oak Park, Illinois, School District.

Author's note:

Special thanks to Judy Harris Helm, professional development coordinator, and Ken Hinton, principal, at the Hinton Early Childhood Development Center, for allowing me to interview them and for providing me with materials.

services, preventing problems from becoming full-blown and expensive crises, or streamlining costly administrative processes such as determining eligibility—must be reinvested in additional services and in serving additional children and families.

• Professional Development

We need new ways of training at all levels to ensure that teachers and other front-line workers, administrators, and policymakers are able to transform the present system. School-linked support systems will require a cadre of individuals who are able to build trusting relationships with children and families, to work comfortably across professional boundaries, and to discreetly and flexibly respond to the needs of children and families to achieve desired results. Administrators and policymakers will need new fiscal, management, and accountability expertise if they are to create environments that will allow more effective and comprehensive support and development systems to thrive. Institutions of higher education must ensure that their programs produce professionals with these capabilities. Schools of education, public health, social work, and other fields should develop a common core of training for all those entering professions that serve children and families. Further, public and private agencies must change their expectations of professional conduct, and must demonstrate a capacity to assist current employees in developing the skills they need in order to function in new systems—systems geared toward attaining specific, positive goals and objectives for children and families through flexible means.

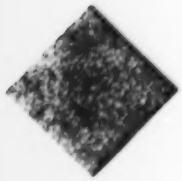
Schools can change internally in many ways and can reach out to other institutions without single-handedly taking responsibility for ensuring the well-being of all children and families.

• Local Governance Structures

We need ongoing, interagency mechanisms for developing and implementing coherent, cross-sector strategies if we are to achieve positive results for children and families. Communities must identify or establish a local authority that represents education, human service, and community organizations. Such a governing body should be responsible for forging agreement on desired goals for children and families, developing new support systems and developmental opportunities to achieve those goals, coordinating fiscal strategies and resource allocations to provide support, and holding agencies and organizations accountable.

The goal of restructuring schools is to ensure that all children and youth achieve at high levels in school and in their communities. To accomplish this, educators across the country are critically examining the nature of schooling. However, efforts to restructure schools must also take into account the necessity of working with families and with the rest of the community to create an overall environment that is conducive to learning and healthy growth and development. Informed changes in school governance, curricula, professional roles for educators, accountability mechanisms, and the nature and quality of interactions with families must be part of broader community efforts on behalf of children.

Bill Shepardson is the director of School/Community Collaboration Projects at the Council of Chief State School Officers. This article is based in part on the Council of Chief State School Officers' 1992 policy statement, Student Success Through Collaboration.



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Toward Family Supportive Child Welfare Systems

by Carol Williams

"It was the best of times; it was the worst of times," wrote Charles Dickens in *A Tale of Two Cities*. Although written at another time and in another context, Dickens' assessment aptly describes the current experience of those promoting a family-supportive approach to child welfare issues—and to working with families involved with child welfare systems.

Challenges Families Face

Families in the U.S. today are under more pressure and face more disadvantages, obstacles, and problems than ever before. From the perspective of child and family welfare professionals, the difficulties and challenges facing children and their families are awesome.

From the perspective of child and family welfare professionals, the difficulties and challenges facing children and their families are awesome.

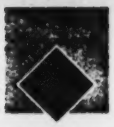
The major indicators of child and family well-being have shown decline over the last two decades. Economic dislocations, downsizing in our largest companies, and technological advances and other structural changes in our economy have taken jobs and the ability to be self-sufficient from many parents, making it difficult for them to support their children financially. The number of children living in poverty continues to increase, but the demands of balancing work and family put pressure on families of all income levels. Drug and alcohol abuse is pervasive in our communities, and its effects have impaired and have diminished the ability of families to care for their children.

Child maltreatment is a persistent major problem. Nearly three million children were subjects of reports to child protective services in 1992, and the number of children in out-of-home care continues to increase—this year nearly a half-million children will be in substitute care.

Many families live in fear—terrorized by violence in their homes, schools, neighborhoods, and communities. Children bear children and families are headed by very young parents who have not reached adulthood themselves.

Pressures on Child Welfare Systems

The service delivery systems designed to respond to families in crisis confront overwhelming pressures. The families they serve have multiple, complex problems that need to be resolved. Caseloads are high, making it difficult to give families the individualized attention they need. No single agency can mobilize the resources needed, and no single worker or agency can resolve all of a family's problems. Too often these factors result in agencies providing families with what they have rather than what families and children need. Many of those who work with families in child welfare systems think their interventions are very late and that earlier interven-



PROFILE

Keeping Children in the Community through a Neighborhood Foster Family Program

The Center for Family Life in Sunset Park
Brooklyn, New York

by Jacqueline Lalley

As a child, being removed from your home and being separated from your parents is a traumatic event—even if your parents have abused you. Being separated from brothers and sisters, having to live in a new neighborhood without old friends, and having to go to a new school make it even more traumatic. And your new, unfamiliar environment includes adult strangers who now somehow act as your parents. This is the status quo in child welfare systems in the U.S. today; it is the traditional mode of placing children in foster care.

Not surprisingly, foster home placements that distance parents from their children and cut children off from community supports contribute to difficulties in rehabilitation and reunification. They substitute one set of problems for another in the lives of children; they treat parents as adversaries and thus don't promote cooperation. In addition, this traditional system isolates efforts to help parents make changes from services provided to their children.

In an effort to propose and model an alternative, in 1989, the Center for Family Life (CFL) in Sunset Park, Brooklyn, added a small neighborhood foster family component to its large range of family support services.

Creating a Healthy Atmosphere for Children to Return to

The Center for Family Life works hard to help parents sustain their children at home, including offering the services listed below, but when placement does have to occur it places children from the community with foster families in the same neighborhood. Once the city's Child Welfare Administration (CWA) determines that placement is necessary, a CFL social worker begins providing counseling, referrals, and supervised therapeutic activities for the child and his or her biological family, to assist them in creating a healthy atmosphere to which the child can return. The biological family also has the support of the foster parents as partners. The same social worker meets with the foster family to address any issues they may have. This arrangement protects the child's well-being while giving the family the opportunity and the resources to make positive changes.

The families and their social worker call upon the resources of the community and of the Center as needed. After the children return to their own homes, they and their biological parents can continue to use any of these services, including counseling, for as long as they need. This form of "after-care," and other elements of the Center's holistic approach of following through with each family, keep staff and participants from seeing the placement as only a forced intervention.

In light of its goal to support and reunify families separated by out-of-home placement of a child or children, the Center for Family Life's foster care program has met with consistent success. Of the 90 children the Center has placed, only four have been unable to be reunited with their families, and these have been adopted. The Center's strategy for guaranteeing the long-term security of children, its permanency planning, consists of assisting families in developing healthy behaviors and a safe setting in which children can thrive. Children are never placed for pre-determined periods of time; the child can be with a foster family for as long or short a period as the birth family needs. The program owes its success to its community nature, its small scale (19 children are currently in foster families), and its connection to the rest of the Center for Family Life's wide-ranging family support services.

CFL: A Comprehensive Community Center

Aside from coordinating this small, community-based foster care program, the Center for Family Life is a comprehensive community center for all of Sunset Park, an impoverished neighborhood of some 100,000 people, 60 percent Latino, 10 percent Asian, and 30 percent Caucasian and African American. Founded in 1978, CFL is open 8:00 A.M. to 11:00 P.M. every day of the week, and is well-known to community residents. The following services are available not only to families involved in foster care, but to all families with a child under 18 living in the household:

- **Counseling**—family, individual, and group sessions
- **Psychiatric and psychological evaluations**
- **Information and referral**—staff connect clients with other social service agencies
- **Foster grandparent program**
- **Infant/toddler/parent program**
- **Extensive after-school programs**—at three local schools
- **Summer day camp**—at least 430 children each year attend programs for children ages five to 12 and 13 to 15
- **Teen center**—three nights a week
- **Adult forums and workshops**
- **Employment services**—job counseling, job search, and job placement
- **Thrift shop**

Replicating the Model

CFL's Neighborhood Family Foster Care Program is widely recognized as a model program; efforts are underway to replicate it in many communities throughout the nation. As part of the Annie E. Casey Foundation's Family-to-Family: Reconstructing Foster Care initiative, the Foundation has funded the Center to provide technical assistance to five states (Ohio, Pennsylvania, Alabama, New Mexico, and Maryland) through dissemination of materials and visits to and from state- and local-level program administrators. The Center's neighborhood-based foster care program, as one of a very few in the country, is providing the example that the states need to revamp public foster care, which includes cutting the lengths of children's stays with foster families and the number of times these children must move. The Casey initiative is working with the five states for nine months to a year to plan changes at the state regulatory level, requiring the participation of local-level foster care administrators in those changes.

tions would result in better outcomes for children and families.

But in the midst of these obstacles there is reason for considerable optimism.

The Bright Side

In the past 15 years we have learned a good deal about what works for families and children. Innovations at the state and local levels have demonstrated that we can achieve positive outcomes. Lisbeth Schorr in *Within Our Reach* documented the characteristics of programs that work:

- The entire family is the unit of service.
- The services are comprehensive and cross the boundaries of disciplines and systems to meet families' needs.
- The services are home- and community-based.
- The services are intensive.
- The services focus on the strengths of families.
- The services empower families to resolve their problems.

All over the country, family preservation and family support services that embody these principles have been developed.

The lessons learned from these efforts have been so powerful that legislation was enacted last year to encourage states to use these insights to reform their child welfare systems, to make child welfare systems more family-focused and family-supportive.

The Family Preservation and Support Services Program

The Omnibus Budget Reconciliation Act of 1993 authorized $1 billion for family preservation and family support programs. By amending Title IV-b of the Social Security Act, Congress provided a five-year capped entitlement program that provides grants to states and eligible American Indian tribes to develop and expand family preservation and family support services. This landmark legislation, one of the Clinton Administration's priorities, earmarks funds specifically for prevention and early intervention services, creating an opportunity for the states and tribes to expand their service continuum to better meet the needs of families and children.

Family preservation services help families alleviate crises that might lead to out-of-home placement of children.

The family support services component of the federally funded program consists primarily of community-based preventive activities to alleviate families' stress and to promote competencies and behaviors that will increase parents' ability to successfully nurture their children. These programs increase families' access to other resources and opportunities available in the community. They also create supportive networks to enhance parents' child-rearing abilities and to help compensate for families' increased social isolation and vulnerability.

Family preservation services help families alleviate crises that might lead to out-of-home placement of children. They work to maintain the safety of children in their own homes, support families preparing to reunify or adopt, and assist families in obtaining supports and services that address their multiple needs in a culturally sensitive manner. If a child cannot be protected from harm without placement, or if the family does not have adequate strengths on which to build, family preservation services are not appropriate.

The U.S. Department of Health and Human Services (HHS), responsible for administering the funds, has encouraged the states and tribes to use the dollars available in the first year to engage in a comprehensive planning process to develop a five-year plan for children's services. This money should allow them to envision and plan for large-scale reform of their child welfare system. Years two through five should focus on

PROFILE

Preserving Families through the Homebuilders Program

by Jill Kinney and David Haapala

Homebuilders serves families in imminent danger of having one or more children placed in state-funded foster care, group care, or correctional or psychiatric facilities. Participating families struggle with child abuse and neglect, mental health issues, delinquency, developmental disabilities, family violence, and drug and alcohol abuse. The program's success rate is high: between 70 percent and 90 percent of children still have not been placed 12 months after intake, and Homebuilders' costs are substantially less than those incurred by placement.

Homebuilders began in 1974 in Tacoma, Washington, with the goal of enhancing the welfare of children by preventing their unnecessary out-of-home placement.[1]

Homebuilders' top priority has always been the physical and emotional safety of children, and the structure of the model was developed around that priority.

Homebuilders' top priority has always been the physical and emotional safety of children, and the structure of the model was developed around that priority. Workers meet with family members within 24 hours of referral; their caseloads consist of only two families at a time; and workers are on-call round-the-clock. Services are offered in clients' homes and in other places convenient for families.

Services include meeting basic needs such as food and housing, individual and family therapy, and assistance with learning life skills. Homebuilders' services are time-limited, usually involving four weeks of intensive services, with approximately 10 to 12 hours of face-to-face time with each client weekly.

Homebuilders emphasizes building on client strengths; a holistic approach; tailoring of services; decision-making partnerships; short-term, specific goal-setting; and acknowledging the importance of worker characteristics and skills through careful selection and training of staff.[2]

There are Homebuilders programs in 12 counties in Washington. In 1987 Homebuilders began operating a demonstration project in the Bronx, New York City, which it turned over to the City in 1990. Currently there are more than 250 adaptations and replications of the model in 30 states and several foreign countries, including Australia, Rumania, and Sweden.

In 1982, the Edna McConnell Clark Foundation, through its Family Preservation initiative, began funding Homebuilders to disseminate information and to train programs on its model nationally and internationally from its training office in New York. Homebuilders offers large site-development programs that can include assistance with requests for proposals (RFP), training for line staff, ongoing technical assistance and quality assurance, and, most recently, assistance blending drug abuse treatment with family support and preservation services.

Responding to Today's Families

Parental drug abuse is now responsible for 60 to 70 percent of placements by the Washington Department of Child Protective Services. Increases in violence and gang problems have been severe. In Pierce County, Washington, between 1990 and 1992, the rate of serious felonies among juveniles doubled. Families and the workers helping them are also coping with increases in homelessness, mental illness, and sexual aggressiveness in youth.

These issues are causing Homebuilders to reevaluate, adapt, and supplement its services in order to respond to today's families and referral workers in the best way possible. The program has incorporated many techniques for drug abuse treatment into its approach, and whereas Homebuilders once assumed that families were ready for change when they were referred, the program now recognizes that many are in the pre-contemplation or contemplation stages leading up to change.[3] Homebuilders has developed and is using a new client self-assessment process; workers also use an approach called Motivational Interviewing to foster participants' sense of self-efficacy so that they will be more likely to participate in the change process and to maintain changes after the worker leaves.[4]

Evaluations Confirm Success

Homebuilders' Family Based Intensive Treatment (FIT) research project showed the Homebuilders model to be successful not only in preventing out-of-home placement, but in changing the behaviors that place families at risk of placement. Nearly 93 percent of children who originally were targeted for out-of-home placement in Utah and Washington during the study were able to stay home due to participation. Twelve months after intake, 67 percent of the

The Family Based Intensive Treatment research project showed the Homebuilders model to be successful not only in preventing out-of-home placement, but in changing the behaviors that place families at risk of it.

children were still at home. Only 14.8 percent of the children receiving more traditional child welfare or mental health services as an alternative to placement were still at home after a year.

But what about the quality of the home environment? Preventing out-of-home placement is only effective if the home is a safe, healthy place for children. The FIT study showed that by participating in a Homebuilders-model program, families improved in an average 26 of 28 areas of child, household, parent, and family functioning. In addition, program staff indicated participants made gains on an average of 22 of the 25 Family Risk Scales devised by the Child Welfare League of America to measure parent and child functioning.

Not only does Homebuilders prevent out-of-home placements—it produces significant improvements in family and individual functioning. The study also showed that Homebuilders' "enabling" services—assisting participants in securing concrete services—resulted in positive outcomes. While program staff and administrators are sobered by the increases in the severity of families' problems, they are gratified to the extent that Homebuilders continues to facilitate change and are excited about the positive responses to their new approaches. The best solutions will come as service providers reach out to one another in order to develop new, more creative ways of helping all.

Jill Kinney is executive director of Innovative Technologies and co-founder of the Homebuilders model.

David Haapala is executive director of Behavioral Sciences Institute (BSI) and is a co-founder of BSI and the nationally recognized Homebuilders program that began in Tacoma, Washington, in 1974.

Both can be reached at Innovative Technologies, 1901 Markham Ave. NE, Tacoma, WA 98482, 206/927-7547.

Notes

[1] KINNEY, J.M., D.A. HAAPALA and C. BOOTH (1991) *Homebuilders: Keeping Families Together* (New York: Aldine de Gruyter).

[2] KINNEY, J.M., K. STRAND, M. HAGERUP, and C. BRUNER (in press) *Beyond the Buzzwords: Operationalizing Key Principles in Effective Front-Line Service.*

[3] PROCHASKA, J.O., and C.C. DICLEMENTE (1982) "Toward a comprehensive model of change." In: Miller, W.R. and N. Heather, eds. *Treating Addictive Behaviors* (New York: Plenum Press) 3-27. MARLATT, G.A. and J.R. GORDON (1985) *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors* (New York: Guilford Press).

[4] MILLER, W.R. and S. ROLLINICK (1991) *Motivational Interviewing: Preparing People for Change* (New York: Guilford).

the implementation of the programs. HHS consulted with a wide variety of people, including state and local representatives, advocates, parents, service providers, judges, and line workers to obtain guidance on how to implement this legislation. Several key themes emerged from those discussions and are reflected in the instructions for states and tribes implementing the program:

- Think big when developing the five-year-plan. Don't create two new categorical programs, but instead use this opportunity and these resources to leverage broader systems change. Engage in the broadest possible training process.

- Envision a new approach to providing services for families and children that will improve their outcomes.

- Focus on principles, not programs. The federal program gives the states and tribes the flexibility to design programs that work in their respective communities.

- Be inclusive. Involve a wide variety of stakeholders in this process of planning and implementation: parents, provider agencies, community-based organizations, courts, and other agencies serving children and families.

Front-line workers, administrators, policymakers, parents—we can all make a difference.

The federal Family Preservation and Support Services Program, coupled with the service approaches that states and communities have developed previously, provides a unique opportunity to create new and more effective ways of serving families and ensuring the welfare of children: providing assistance earlier, building the capacity of parents to protect and nurture their children, weaving services into the fabric of the local community, and encouraging coordination among service providers at every level of the system.

Front-line workers, administrators, policymakers, parents—we can all make a difference. We can improve the lives of children and their families, and we can strengthen and support them, as well as their communities. The Family Preservation and Support Services Program is a new and valuable tool, and we need to use it to achieve these goals. Achieving our goals will take persistence and commitment—from all of us.

Carol Williams, DSW, is associate commissioner for the U.S. Children's Bureau, Administration for Children, Youth, and Families. She has published on a variety of child welfare issues, including adoption and permanency planning for minority children.

PROFILE

KALEIDOSCOPE: Hope at the End of the Road

by Kathy Goetz

Kaleidoscope is a not-for-profit child welfare agency in Chicago that serves the children everyone else has given up on: children who have been too difficult for foster family after foster family; babies with HIV whom most are afraid of; children who have been left behind, ignored, missed, or actively rejected. This also means working with kids deemed too violent or too dangerous for the child welfare system, those whom Kaleidoscope calls the "severely emotionally or behaviorally unique."

Kids such as Alan. As a child Alan liked sports, was tremendously energetic and bright, but also became uncontrollably angry—and when he was angry he was violent. By the time Alan was 15, after his family had tried everything the social workers suggested, he was deemed too dangerous to live at home—or with a foster family—and Alan was institutionalized. At the hospital, Alan attacked a doctor and a nurse and was sent to prison. At 16 he was placed in solitary confinement for having beat up another prisoner; he ripped the door of his cell off its hinges and assaulted a guard. It was then that Kaleidoscope became involved.

Kaleidoscope has individual contracts with the Illinois departments of Children and Family Services, Mental Health, and Corrections: all three refer their most difficult cases to Kaleidoscope. Kaleidoscope works to normalize the lives of children with severe disabilities or emotional or behavioral challenges, and believes that "children can best learn to become normal, competent adults if they live in and learn from a normal environment—a family, a neighborhood, a community." So when the Illinois Department of Corrections called about Alan, Karl Dennis, Kaleidoscope's executive director, searched Alan's file for strengths to build on—for resources in Alan's life that would help normalize his situation. Dennis discovered that Alan's mother had visited him once a month the whole time he had been in prison. It was a long trip, and Alan's mother had no car. She took three buses and traveled two hours each way one Sunday every month.

So Karl Dennis went to visit her. Alan's mother didn't want to let him in. Alan's former social worker had warned her that this man would try to convince her to let Alan come home and, heartbreaking as it was for her, she didn't think that she could do that in good conscience. She knew that living with Alan would jeopardize her job, her relationships, and perhaps her life. Dennis was persistent, and she finally agreed to talk with him, if only because he promised to go away if she gave him 15 minutes and to come back every day if she didn't. Dennis asked what it would take for Alan to be able to come home. And they started to talk.

"Well, when Alan was here he wouldn't go to school," Alan's mother said. "I'd be at work and the school would call me because Alan wasn't in school, or if he went to school, they'd call me because he'd be in trouble and they'd want me to come get him."

"What if we hired people who would take Alan to school and make sure he stayed there, and if they dealt with any trouble Alan got into at school instead of your having to leave your job?" Dennis asked.

"Well, that would be good. But Alan would come home from school before I get home from work and then he'd get in trouble."

"Alan likes sports. What if we took Alan to an after-school sports program and helped him do his homework and brought him home tired an hour after you came home from work?"

"That would be good, but still, when Alan gets angry, I can't talk to him and he's dangerous."

Dennis asked Alan's mother if she could see signs before Alan got to the point where he exploded; she said she could tell about an hour and a half before. Dennis asked if it would help to have people she could call, around the clock, who would come within 45 minutes and take care of Alan when he got angry. Dennis also promised to work with Alan's mother to solve any problems that might arise and said that if the solutions they'd discussed didn't work, they'd try something else. He assured Alan's mother that Kaleidoscope would not give up on Alan. Alan's mother finally agreed that he could come home. Kaleidoscope worked with the family for three years, until Alan was able to live on his own.

Wrap-around Services

Too often social service agencies give families what they have to offer and not necessarily what the families need. The strategy of individualizing services to provide exactly what a family needs is what Dennis calls "wrap-around services." Dennis says, "All good services should include a wrap-around component. Children in specialized foster care should receive services that are highly tailored to their needs and that may

be changed when a particular approach is not working. All too often, services are not flexible, due to an allegiance to a particular model of services delivery or because funding sources allow only limited interventions. Wrap-around intervention dictates that 'whatever works' should be the model and that unconditional care or never giving up on the child should be the philosophy."

Alan's case is not particularly unusual for Kaleidoscope; the agency provides wrap-around services to many of those referred to it and individualizes all service plans. The intensity of services is flexible, so each child receives as much as is needed at any one time. Wrap-around services are community-based, family-focused, cost-effective, and unconditional (no one is ever ejected or rejected). They build on the strengths of the family and are sensitive and responsive to participants' culture. Interventions are developed or approved by an interdisciplinary services team consisting of the parent or guardian and all social service professionals and significant people in the child's life (neighbors, relatives, friends) who can be helpful in developing effective services for that child. The child is also on the team, unless such an arrangement would be detrimental to the child's development.

The Most Difficult-to-Serve Children

Kaleidoscope was founded in 1973 in response to a newly-instituted policy that returned more than 200 children to Illinois from institutions in other states. Most private child welfare agencies could not or would not include these most difficult-to-serve children in their programs. Kaleidoscope started with its wrap-around service philosophy and its policy of unconditional care and has become nationally recognized as one of the leading agencies in community-based care, serving more than 600 family members per year.

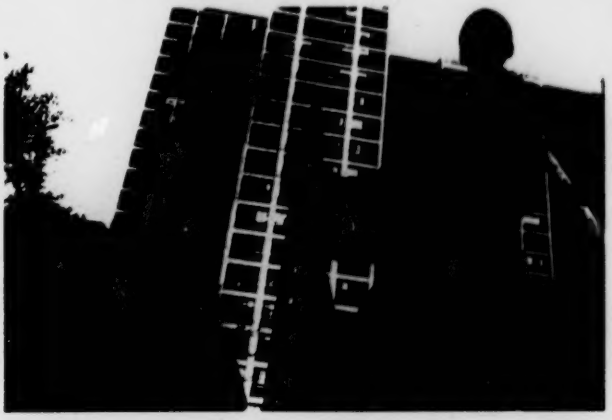
Kaleidoscope provides three basic programs: the Satellite Family Outreach, the Therapeutic Foster Family Homes Program, and the Youth Development Program. Children can move from one program to another as their needs and circumstances change. All three have become national models of family- and community-based care.

• Satellite Family Outreach

Kaleidoscope's largest program serves 360 family members (such as Alan and his mother) each year. Satellite Family Outreach successfully reunites children in residential treatment with their families and prevents unnecessary removal of children from their homes by providing the individualized services families need. Satellite is one of the oldest and largest family-based programs in the country.

• Therapeutic Foster Family Homes Program

Kaleidoscope realizes that not all children can stay in their homes. This program trains and employs professional foster parents who provide full-time care in their own homes to handicapped and troubled youth. These foster parents are surrogate parents; they provide a loving, safe, and nurturing home environment and perform all the tasks parents would, including finding appropriate schools for the children and securing therapy and medical treatment. Children in this program may stay with their foster parents until adulthood; return to their



homes eventually; or, as teenagers, move from foster homes to Kaleidoscope's Youth Development Program for independent living. Within the Therapeutic Foster Family Homes Program, Kaleidoscope offers two very specialized services: the Adolescent Parents Program, which provides professional foster care for state wards who are pregnant or parents and for their babies; and the STAR Program (Specialized Team for AIDS Relief), which provides professional foster parents and expert medical care for babies with HIV, ARC, or AIDS.

• Youth Development Program

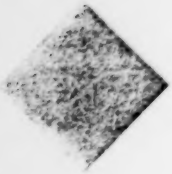
This is an independent living program for older youth who have grown up in the foster care system. Kaleidoscope places and supervises these teenagers in apartments in the community and helps them learn to live on their own—no small task, since approximately 50 percent of the youth are parents and many are functionally illiterate and lack work habits and skills. The staff helps program participants develop job-seeking and retention skills, enrolls youth in basic education classes, teaches independent living skills such as maintaining an apartment and budgeting, and helps the teens overcome behavioral problems. In addition, Kaleidoscope provides opportunities for these young people to develop a supportive network with other program participants, program staff, and community members. Research has shown that most people are not entirely financially independent from their parents until age 28; Kaleido-scope's long-term intervention strategy recognizes that many teenagers—and perhaps especially these—are not able to be self-sufficient by the age of legal majority.

The work of Kaleidoscope appears to be based on an idea that is simple and commonsense, but one which should be impossible to execute. Listening to families, determining what they need, and crafting a service plan with and for them appears obvious and straightforward. But who would pay for it? Wouldn't it be too expensive? Just think of all the resources and staff required to plan and deliver services on a case-by-case, individualized basis.

The answer is that Kaleidoscope is doing it, and for the population it serves, wrap-around services are less expensive than the alternative: institutionalization. The insight of the family support movement, however, is that holistic, family-focused, community-based, culturally relevant prevention and early intervention are typically cost-effective as they help to avert dire situations that are more costly in both human and economic terms. The question from a family support perspective is: What if, when Alan was five or six years old, his mother had had access to a family support program that supported her and linked her family with specialists who could diagnose and treat Alan's incipient problems? How much of the pain and trauma that has characterized both of their lives could have been avoided?

Kaleidoscope is increasingly working with states and child welfare agencies who want to adopt its wrap-around service philosophy. Over the last three years Kaleidoscope's Training Institute has trained or consulted in 46 states and several foreign countries. Kaleidoscope also seeks to impact social policies. For more information on the Training Institute or any of Kaleidoscope's programs write: Kaleidoscope, Inc., 1279 North Milwaukee Ave., Chicago, IL 60622, or call 312/278-7200.

Kathy Goetz is director of publications for the Family Resource Coalition.



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OVERVIEW

HEALTH CARE: The Need To Build Bridges

by Christopher Shearer

The health of children and families is not solely a concern of the health care field. Health is a multi-faceted issue that affects and is affected by education, mental health, disabilities, welfare, transportation, and nutrition, among other factors. Each of these issues in turn affects the activities of the family support movement. As more and more health care professionals recognize the need for providing social and psychological supports in addition to traditional clinical care, opportunities for collaboration between health care providers and those in other social service professions, including family support professionals, are increasing.

Health Is an Education Issue. Teachers know that learning comes more easily to a healthy child than to a sick one. Any health problem—hunger, poor vision or hearing, high levels of lead in the blood, dental caries, child abuse—can interfere with learning.[1] And just as health affects education, education affects health. Good health education ensures that children will begin and maintain healthy patterns of behavior for a lifetime, and that they will learn how to get primary as well as preventive services. The health and education sectors, however interrelated, have historically approached programs and services for children from very different perspectives.[2]

Health Is a Mental Health Issue. The nation's children are growing up in a turbulent world, where poverty, single-parent households, drugs, and violence are daily realities in too many places. Amidst this turbulence, an alarming 12 to 15 percent of children suffer from mental disorders. At school, in the health care system, and in society in general, the odds are stacked against children who have or are at risk of having mental disorders. As these children mature into parents and family-builders they continue to face unfavorable circumstances. In our present health and social service system, no agency alone has sufficient resources to treat all the children who need mental health care. What is needed is a concerted, collaborative effort on the part of health and mental health professionals, educators, communities, and families to focus on the mental health of children.[3]

Health Is a Disabilities Issue. Disabilities and health needs are most obviously and directly linked when children's disabilities *are* health-related. Additionally, some children's disabilities, though not physical, increase their risk of acquiring health problems. The health problems facing disabled persons can be procedural as well as substantive. Despite numerous federal and state programs (such as the Individuals with Disabilities Education Act) many children with disabilities do not receive the health care they need. The demands placed on family members, establishing independence during the transition to adulthood, transportation, and housing, all are special health-related challenges facing disabled individuals.

Health Is a Welfare Issue. Welfare is a work issue. But good health is critical to employability, and adequate income or insurance is necessary to get health services. People in poor health are more likely than healthy people to be absent from work or to have performance problems, and may not be able to work at

all. For many at-risk families a primary source of health care is Medicaid, the federal/state matching entitlement program that provides medical assistance for low-income persons who are aged, blind, disabled, members of families with dependent children, and low-income pregnant women and children. Notably, Medicaid eligibility generally is linked to eligibility for Aid to Families with Dependent Children (AFDC) and the Supplemental Security Income program (SSI).[4] Families with members who have serious chronic health problems may find it difficult or impossible to make the transition from welfare to work—especially if "work" means a minimum-wage job with no health benefits.

Health Is a Nutrition Issue. Although we are learning more about the importance of nutrition to good health every day, hunger and poor nutrition in the United States are on the rise. One out of every eight U.S. children under age 12 is hungry.[5] Children who are hungry or undernourished tend to be irritable, apathetic, and lethargic, and tend to have greater difficulty fighting infection than healthy children; all these factors interfere with their ability to learn.[6] Whatever the exact cause of a child's poor nutrition or hunger, the health consequences can be serious and can affect many elements of family life. Nutrition is affected by income, environment, and education, and can have a profound impact on the health and well-being of individuals served by providers in all disciplines. Staff of federal initiatives (such as the Special Supplemental Food Program for Women, Infants and Children [WIC]; Food Stamps; and the National School Lunch Program), school personnel, food service workers, dieticians, nutritionists, health professionals, and community outreach workers all play vital roles in assuring good health through nutrition.

Health Is a Transportation Issue. Transportation is often overlooked in discussions of the health services system. Many families who need health services lack the transportation they need in order to receive them, and are effectively denied health care. Health care reform may increase the number of families

PROFILE

MOTHERNET:

Training and Technical Support for Home Visiting Mothers

Mothers throughout the world are reaching out to other mothers and pregnant women in their own homes. By providing support, health education, and access to community health and social services, lay home visitors guide women in need through pregnancy and the first few years of child-rearing. But how can home visiting programs maximize the potential of this powerful avenue for education and support? And how can concerned community members start a home visiting program in the first place?

MotherNet has the answers. Formerly the Resource Mothers Program of the National Commission to Prevent Infant Mortality, MotherNet is a program of the International Medical Services for Health (INMED) that is committed to assisting local communities and state and federal governments in developing and implementing home visiting programs for pregnant women and mothers. These programs' goals are the birth of healthy, full-term babies and the development of successful parenting skills. Studies show that home visiting programs achieve these goals, significantly reducing the incidence of low-birthweight babies and promoting parenting skills. And they are extremely cost-effective.

The success of home visiting mothers' programs depends largely on high-quality training for program staff, training that can be hard to find. Fundraising and outreach to potential participants and to the larger community are other challenges. MotherNet helps by offering four areas of training:

• Resource Mothers Supplemental Training
MotherNet provides supplemental training for women who are (or will be) resource mothers in a home visiting program. The participatory training covers topics from MotherNet's *Resource Mothers Handbook* and incorporates locally relevant issues. (Maximum 20 participants per session)

• Training of Trainers
MotherNet provides program staff to train resource mothers in the skills they need to conduct home visits and to recruit and meet the needs of at-risk pregnant women. (Maximum 20 participants per session)

• Start-Up Training
MotherNet offers staff of new programs start-up and implementation tools and skills, covering topics in MotherNet's *Implementation Guidelines*. Training uses a participatory format that allows for individual program variations. (Maximum 10 participants per session)

• Materials Development
MotherNet helps programs design and develop new materials and adapt existing materials for a specialized population. They cover topics such as needs assessment, pre-testing and field-testing, focus group discussions, and other means of participant community research. (Maximum 10 participants per session)

Two or more of these sessions can be combined into more extensive workshops to suit specific programs' needs. MotherNet also assists programs in implementation and evaluation; programs receiving either Resource Mothers Supplemental Training or Training of Trainers usually arrange for MotherNet to conduct follow-up reviews within six months of the session. These site visits enable MotherNet to provide localized support for program staff, to ensure that the program is running smoothly, and to assist program staff in reinforcing or modifying original program objectives. The length of on-site training and technical support, as well as the number of participants and the cost, vary from program to program.

MotherNet can be reached at INMED, 45449 Severn Way, Suite 161, Sterling, VA 20166, 703/444-4477 (phone) or 703/444-4471 (fax).

PROFILE

Vermont's Visiting Nurse Association: A Tradition of Caring

In 1906, long before the advent of federal legislation and funding streams that encourage social service providers to support families, the Visiting Nurse Association (VNA) in Burlington, Vermont, organized a core of nurses and care providers committed to assisting individuals in the context of the home and the family. Since then, VNA has been there for families and individuals in Chittenden and Grand Isle counties, Vermont, when their needs are most immediate—during times of stress and physical vulnerability. With a mission to provide high-quality services that respond to the health needs of people in their homes and at other sites in the community, VNA's 800 staff members see in "health needs" a whole scope of human needs: in addition to nursing care, parents with sick children may need special childcare; those dealing with death may need spiritual support; new and expectant mothers may need information on nutrition or on what to expect during childbirth; elderly community members may require only basic assistance in order to keep living at home.

All VNA staff, both volunteer and professional, provide health care while working cooperatively with participants and promoting their self-determination and independence. "We have always educated clients and families to help themselves as part of our role," says one visiting nurse. "Home care has changed a great deal, but the basics are there, and the basics are taking good care of the patient."

The Visiting Nurse Association's range of services maximizes the potential of public health nurses; pregnancy and well-baby educators; adult day-care professionals; hospice care-givers; home health aides; social workers; physical, occupational, and speech therapists; homemakers; volunteer coordinators; and other community members. The talents of these VNA staff are channeled through a range of programs that are linked together to provide holistic care to families. These include:

Maternal Child Health Services

The Maternal Child Health Services (MCHS) program is a good example of VNA's holistic approach. MCHS staff work together to provide a continuum of care for children and families based on their needs and their developmental potential. "We work to help families get whatever they need to grow and develop," says Division Director Janet Munt. Whatever the reason for referral, says Munt, MCHS services help build strong families and, ultimately, a strong and supportive community.

The MCHS program has four components:

- Prevention and early-intervention **home visiting services**
- The **Family Room** center-based primary prevention program
- **Expectations** childbirth and parenting preparation classes
- **High-tech pediatrics** and care of sick children in the home

• Home visiting

In the home visiting program, nurses with special training in child development and mental health intervention, clinical social workers, an early childhood specialist, and family educators collaborate to bring services to families' homes. This health care team helps prepare pregnant women for childbirth; provides postpartum check-ups and parent education; assesses family interaction; and offers preventive services for families with handicapped children and those at risk for abuse and neglect, domestic violence, or substance abuse. In all medical risk situations, nurses are working under doctors' orders. Obstetricians and pediatricians and area hospitals refer families to the program. Medicaid and some insurance pay part of the costs of some visits. Home visiting is MCHS's most interventional arm; many of the more than 700 families and pregnant women served each year have multiple problems, and many are impoverished and are unprepared for childbirth. As families stabilize, MCHS assists them in entering programs that help develop their strengths—such as the Family Room.

• Family Room

About 400 families each year (half of them participants in the home visiting program) go to the Family Room at H. O. Wheeler Elementary School in Burlington. During drop-in hours, families can play together; use the library or phone; pick up maternity or children's clothes; listen to and read stories; eat lunch with other families; gather after school; or take sewing, craft, or exercise classes. At other times parents can participate in parents groups or workshops on discipline, pregnancy and childbirth, infant care, children's play, and other topics. Children's play groups and preschool services are available at the Family Room. All these services are free of charge and offer families support that can prevent problems.

• Expectations

"The overarching theme binding the MCHS programs together is parent education," says MCHS Director Janet Munt. Expectations, a set of childbirth and parenting preparation courses, is one component of that parent education. Families pay on a sliding scale to enroll in any of 33 six-week childbirth classes, seven two-week refresher courses, seven three-week baby parenting courses, and 19 breast-feeding classes each year. These classes aim to give parents and their partners the knowledge they need to make choices that promote their own and their children's healthy development. One-week classes for siblings are also offered.

• Pediatric Care

The Maternal Child Health Services' high-tech pediatric home visiting service assists families in securing the care and equipment they need when a child returns from intensive care at a hospital and provides ongoing case management services.

Home Care

As well as providing health care, VNA Home Care nurses are case managers for those with acute and chronic illnesses who

are living at home and their families. Nurses coordinate their own services with those of home health aides; physical, occupational, and speech therapists; psychiatrists; social workers; and homemakers.

Homemaker Program

To enable people to stay at home who might otherwise be unable to, trained homemakers assist with meals, housework, errands, and personal care, and offer companionship.

Care Connection

This private duty registry puts patients in touch with skilled nurses and homemakers who can assist in home, hospital, and residential care facility settings.

Hospice of the Champlain Valley

This care program helps those with terminal illness and their families cope with death by living life to its fullest. An interdisciplinary team of physicians, nurses, a social worker, a spiritual consultant, a volunteer coordinator, and volunteers collaborate to meet the families' needs. A "bridge" provides care for people with chronic illnesses such as AIDS who don't yet need hospice care.

Adult Day Programs

Get Up and Go helps and encourages frail elders and physically handicapped adults to live as independently as possible; New Hope, a model program for Vermont, offers rehabilitation, support, respite, and education to cognitively impaired adults and their families.

Tricounty Foster Grandparent Program

Volunteers 60 years and older provide love, patience, and guidance to children with special needs. VNA gives the volunteers, whose incomes are limited, stipends.

VNA served 4,238 patients in 1993, and conducted 142,847 home health visits. The cost benefits of home care versus institutionalization are clear: the Association saved taxpayers $1 million last year by staying below the cap imposed upon Medicare compensation.

eligible for care, but will not necessarily provide concrete access to services. Transportation and access concerns are major reasons to support community- and school-based health care.

Families Need More than Clinical Care

Clearly health is an interdisciplinary concern that is strongly connected to all aspects of a family's self-sufficiency and well-being. The family support movement can and should help the health sector provide families with more than traditional clinical care. Such collaboration can broaden the perspective of health professionals, helping them to view the individual's health issues in the context of his or her family and to consider the interrelated nature of family needs. This type of collaboration can also assist families in promoting health and preventing disease, and it can improve access to existing care services. In addition, family support services will become even more effective as they implement lessons learned from successful health models, such as: Maternal and Child Health programs, home visiting, public health nursing, and the use of paraprofessionals. These efforts provide a range of social and psychological supports to supplement and prevent the need for clinical care, are fertile ground for as well as examples of health/family support collaboration.

• Maternal and Child Health Programs

Maternal and Child Health programs are successful at assessing, treating, and preventing the health problems of pregnant mothers and children through federally funded immunizations and community-based activities. Legislative support for these programs comes from a variety of sources: Medicaid initiatives, substance abuse programs, home-visiting acts, health care reform bills, funds earmarked for nutrition and immunization, and health center and economic development initiatives. Perhaps the most effective and best-known federally funded programs include the Maternal and Child Health Block Grant, Community Health Centers, the Childhood Immunization Program, and the National Health Service Corps.[7]

• Home Visiting

Home visiting is a proven way to support, motivate, assist, educate, and advocate for families with regard to their health concerns, and to locate families who need assistance. Home visiting programs send workers such as nurses, social workers, educators, counselors, therapists, and trained community workers into families' homes; the capacity for one-on-one exchange for a variety of populations in different settings that is offered by this approach, which has existed for at least a century, represents a unique and special "helping hand."[8] As part of a comprehensive effort to link families to supportive services and to educate families to meet their own needs, home-visiting programs can be an enormously effective bridge from family support programs to health care programs and health professionals.

• Public Health Nursing

The nursing profession is an essential component of the traditional health disciplines. One recent clinical specialty, public health nursing, is invaluable in providing supportive services to families in their own homes and communities. Public health nurses, who focus on preventing disease and promoting health in the community, have revised public-health training based on the premise that people and families, rather than diseases, should be addressed. A single well-trained nurse working in the community can recognize and cope with multiple problems. Most state health departments have separate bureaus of public health nursing, and public health nurses are often employed by local health departments or by other institutions as "community nurses."[9] In addition to performing assessment and education activities, public health nurses are uniquely equipped and positioned to identify families' needs and to provide them access to additional services.

• Paraprofessionals

Not extensively formally trained in the health professions, paraprofessionals most often are concerned community members who provide their neighbors with much-needed advice and referrals through programs operated by professional health and social service agencies.

PROFILE

Swope Parkway Health Center:

Combining Family Health and Welfare with Community Development

by E. Frank Ellis

The family is the heart of any community. As a community health center, the Swope Parkway Health Center's business is to keep that heart healthy and strong. The center serves a low-income community in the core of urban Kansas City: families who are vulnerable to the same problems plaguing urban areas across the country. The Center's mission is to care for the physical, mental, and spiritual well-being of family members. Therefore, strengthening the family may be the Swope Parkway Health Center's most important objective. And as staff, administrators, and program participants aspire to fulfill that objective, they embrace a holistic approach that blends comprehensive health care for all family members with child development and day-care services as well as grassroots community development—all within a three-mile radius of a new health and family services campus.

Primary Health Care

The health care aspect of the Center incorporates a wide spectrum of outpatient and day treatment services for the whole family that are available under one roof. These services range from medical and dental care to a comprehensive mental health center, case management, nutritional education, and outstation entitlement eligibility processing. In addition, a health ministry program engages area churches in promoting health and brings spiritual counseling to day-treatment and residential-treatment program participants.

Staff counsel families on a routine basis and operate a number of specialized programs that focus on changing unhealthy family dynamics that so often undermine family stability. And at the same time, the Swope Parkway Health Center provides tools to assist parents in coping with the challenges of raising children within the context and constraints of poverty. These programs, briefly described, are:

• Community Health Project

This outreach and case management project uses case-finding techniques to enroll women during early pregnancy and follows them through delivery until the infant's first birthday. Many of the women served are often young high school students with little family support. Social workers work with families, building on family strengths to resolve the issues that have led to the youngster's alienation. In addition, pregnant enrollees are offered parenting and infant care instruction. Home visits are frequent following delivery to help alleviate the fears many of the mothers have when faced alone with the awesome responsibility of a newborn. Staff work with the mother to ameliorate her fears, to help her bond with the infant, and to teach her basic infant care techniques.

• Families First

This intensive in-home intervention program targets families whose children are at high risk for out-of-home placement. The goal of the intervention is to keep the family intact. Each therapist has a maximum of two families at any one time. The programlasts for six weeks, during which families receive daily visits or phone calls from the therapist, who helps the family learn better patterns of interaction and coping. The Center runs a weekly support group for families who have completed the intensive intervention phase.

• Families At Risk

Families who exhibit signs of dysfunction or disintegration are welcome to participate in this program. Therapeutic groups are conducted for children and parents. The adult groups focus on parenting skills, conflict resolution, and family responsibilities. Children's groups also deal with conflict resolution; children are guided to learn more effective interactions with peers, siblings, and parents.

• Images

This program prevents substance abuse by imparting anti-drug messages to youngsters ages six to14 and their parents through a number of channels. Children participate in dance, drama, creative writing, music, and art classes into which anti-drug themes are interwoven. Parents reinforce the classroom messages while receiving parenting instruction and classes in furniture refinishing, tailoring, hair braiding, and other skills that can enhance their employability. Professional instructors teach the classes, and each class is supervised by a qualified mental health professional who looks for signs of potential child abuse or neglect, referring the parents and children for more intensive therapy as needed.

• Champs

This child abuse and neglect prevention program targets children whose parents suffer from serious and persistent mental illness. Through group activities, the children are taught about their parents' illness, how best to cope with that illness, and what to do in emergencies. Parents are given parenting tips and referrals for help with their illness. Children and parents enjoy supervised recreational outings during which they practice mutually supportive interaction and receive feedback from mental health professionals.

• Co-Dependency Program

The Co-Dependency Program is a therapeutic approach to empowering family members of those in treatment for substance abuse. Staff guide families to replace their unhealthy behavior patterns and interactions with behavior that will strengthen the family unit and will ultimately provide the support the substance abuser needs to maintain a drug-free lifestyle.

Community Development Efforts

The programs described above work well in meeting the physical, mental, and spiritual needs of families. But because poverty (with its symptoms of neighborhood blight and drug infestation) continually threatens family health and stability, Swope Parkway Health Center has taken the initiative in establishing a grassroots-based community development program called Community Builders. In one of its initial actions, Community Builders successfully rid the neighborhood of drug houses and gained the City's commitment to improve street lighting and to increase police patrols.

Central to the success of these community development efforts is the Center's

campus, which houses a residential substance abuse treatment facility. Presently overcrowded, the facility will be replaced by a new one, which the Center is currently building. Swope Parkway Health Center soon will share its campus with a childcare and child development facility, which will charge for services based on a family's ability to pay, and an alternative school for 14 and 15-year-olds.

Community Builders is heading community redevelopment efforts that, when completed, will include a range of moderately priced housing alternatives in and around the Center's campus. These include 42 new duplexes; a subdivision with 55 single-family units; 30 renovated single family units; a retail center; and a 50-unit housing project for the elderly. A new public library, a new post office, and a recreational lake (which the City is building) will complement this development. Furthermore, Community Builders is negotiating with the Missouri Division of Family Services to place a satellite center in the area to assure the community ready access to state-operated services.

Community Builders' development will change the makeup of the community, bringing together low- and middle-income families whose commitment to preserving neighborhood stability unites them. This vision of a thriving, self-contained community of families is well on its way to reality, largely due to the involvement and support of community residents. The employment opportunities in construction that minority contractors are generating will go far to energize the area's sluggish economy, and the long-term benefits of community development for families are immeasurable. The Swope Parkway Health Center's unique melding of health and family services with community development serves as a model for other cities looking for answers to suburban flight and urban disintegration.

E. Frank Ellis is president and CEO of Swope Parkway Health Center. He can be contacted by calling 816/923-4545 or writing Swope Parkway Health Center, 4900 Swope Parkway, Kansas City, MO 64130.

Paraprofessionals can help parents and children use existing health care programs effectively. Perhaps the greatest advantage of paraprofessionals, like home visitors, is their familiarity with and acceptance by the community. Trained non-professionals can provide vital links to services by acting as community ombudspersons. Paraprofessionals are most effective in communities in which health and social service agencies work together in a collaborative manner. They benefit from strong skills in observing, organizing, listening, supporting, probing, interpreting, and gently confronting.

Committing to Family Support

Building bridges to the health sector is an increasingly important element in the success of family support programs, and health care professionals' understanding of the family and cultural context of patients is an increasingly important element in their success in meeting family needs. Health outreach activities, like the ones described above, and one-stop shopping (creatively making health and social services convenient and accessible to families in need) are good first steps. But discipline-specific outreach and co-location, while outstanding and long-overdue, are not enough. Professions must also *collaborate* with one another across disciplines if they are to effectively address the inextricably linked needs of children and their families.

In order to increase collaboration between family support providers and professionals who manage health care services, both must:

- understand and be able to communicate the interdisciplinary and interconnected needs of children and families;
- be familiar with and be able to apply models for successful interdisciplinary cooperation;
- have a commitment to acting cooperatively with other stakeholders, including families themselves; and
- know how to forge and maintain collaborative efforts.

Making a commitment at all levels—national, state, and local—to care for communities and families and to assist them in their efforts to care for themselves requires supporting the approach of the family support movement. Such an investment would make our nation's complicated and fragmented health care system better able to meet the health needs of American families.

The insightful interdisciplinary models described in this section provide real-world examples of the role of health in family support and vice versa. From drug abuse counseling to health education to community development activities, Vermont's Visiting Nurse Association, the International Medical Services for Health's MotherNet project, and the Swope Parkway Health Center highlight the success of efforts to place the family first in health care.

Christopher Shearer, M.A., is co-coordinator of the National Health/Education Consortium (NHEC), a 59-member consortium of national education and health professional associations. NHEC works to design strategies to better coordinate health and educational services and programs for children by improving public policy, strengthening interdisciplinary communication, and disseminating information, program models, and practices. Please feel free to contact NHEC at Suite 310, 1001 Connecticut Ave. NW, Washington, DC 20036, 202/822-8405.

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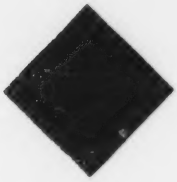

Section IV: Youth Development

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Youth Development and Family Support: Parallel Movements

by Karen J. Pittman

Citizen concern about youth problems is escalating. The sheer number of task forces, reports, and media specials about adolescents indicates that many Americans believe our youth are "at risk." Indeed, the possible pitfalls of adolescence are great: drug and alcohol abuse, unprotected and premature sex, school failure, and delinquency. But the potential for productivity and growth during adolescence is equally great. This is also a time when young people can begin to think critically and act deliberately. They can learn and respond to the requirements for a healthy life; can contribute to the life and revitalization of their communities and neighborhoods; can actively prepare for and even begin careers and lifestyles; and can develop nurturing relationships that sustain them and others. These abilities reflect the outcomes of positive youth development and are the foundation for successful adulthood.

> *I knew that whatever we designed had to be holistic; had to build a rapport with them; had to be empowering; had to have built-in incentives; had to interface with the schools, the community, and parents; had to involve a protracted interaction between these young black boys and positive male role models; and had to focus on helping them develop overall into responsible adults—sexually, yes, but also emotionally, intellectually, academically, and socially.*
>
> *—Ernest McMillan, program coordinator, Fifth Ward Enrichment Program, a school-based male responsibility program in Houston, Texas*

Unfortunately, as a society, we seek to merely reduce youth problems. We rarely emphasize or promote youth development in any sustained way. For years, Americans have accepted the notion that—with the exception of education—services for youth, particularly publicly funded services, exist to address youth problems. We have assumed that positive youth development occurs naturally in the *absence* of youth problems. Such thinking has created an assortment of youth services focused on "fixing" adolescents engaged in risky behaviors or preventing other youth from "getting into trouble."

Preventing high-risk behaviors, however, is not the same as preparing for the future. Indeed, an adolescent who attends school, obeys laws, and avoids drugs is not necessarily equipped to meet the difficult demands of adulthood. Problem-free does not mean fully prepared. There must be an equal commitment to helping young people understand life's challenges and responsibilities and to developing the necessary skills to succeed as adults. What is needed is a massive conceptual shift—from thinking that youth problems are merely the principal barrier to youth development to thinking that youth development serves as the most effective strategy for the prevention or amelioration of youth problems. Nothing short of

PROFILE

Providing Services and Advocating for African American Youth and Families

New Concept
Self Development Center, Inc.
Milwaukee, Wisconsin

The New Concept Self Development Center (NCSDC), a nonprofit, human service agency in the heart of Milwaukee, operates from three sites in low-income, African American neighborhoods. Initially, NCSDC provided mental health services to families in crisis. While that is still part of its agenda, the agency has implemented a range of prevention and family preservation programs. Its current focus is on mentoring and counseling adolescents and preventing teenage pregnancy.

NCSDC addresses some of the most intractable problems facing poor communities in this country: teenage pregnancy, violence, child neglect, health and mental health problems resulting from substance abuse, stress, and poverty. Its objectives are:

- to preserve families and increase the effectiveness of parenting,
- to decrease the potential for sexual assault, child abuse, and domestic violence in the homes of low-income and minority families, and
- to improve the quality of life of parents and children who are experiencing temporary or ongoing difficulties.

NCSDC offers a diverse array of services—more than 15 programs—all culturally relevant and geared to empowering families. The agency views its major role as one of facilitator, helping children, youth, and families recognize their strengths, reach their potential, and constructively channel their energy. The agency provides some services on a walk-in basis or through telephone contact, but its strength lies in its structured programs, some of which are:

- **Each One Reach One,** a teen pregnancy prevention program providing role models, group counseling, and cultural activities to boys and girls seven to 13 years old living in Hillside Housing Development
- **Parents as Teachers of Human Sexuality (PATHS),** a family life education program that trains parents to conduct human sexuality sessions in their neighborhoods, churches, and community agencies
- **Young Parents On the Move,** offering weekly group counseling and parent education for pregnant youth and young mothers and fathers ages 12 to 21
- **Home Management Skills,** an in-home parent education program aimed at preventing child abuse and neglect
- **Case management services** for Parental and Family Responsibility, one of the state's welfare reform initiatives, designed to prevent repeat pregnancies and promote positive life options for teen parents

In addition, NCSDC participates in collaborative efforts, including being lead agency in a five-year research study on teenage pregnancy prevention and welfare reform.

The agency's approach has proven effective. In a follow-up study of 103 girls in the agency's pregnancy prevention program, only three had become teen parents—a much lower rate than girls not involved in any structured program.

A well-established and recognized agency after 19 years of active community involvement, NCSDC has grown from its two founders to a staff of 60 and a budget of over $3 million. Its longevity can be attributed to its commitment to the community, its belief that everyone who walks through its doors has something to offer society, its flexibility, the breadth of programs it offers, and its evolution from providing services to advocating on behalf of the needs of African Americans.

Through the efforts of NCSDC, major public and private institutions in the city have become cognizant of the need for prevention programming, comprehensive services and service delivery, and cultural relevance for African American and low-income children and families. "Our presence makes them aware of the unique needs of African Americans," stresses June Martin-Perry, who believes that the institutions that make social policy or plan, deliver, or fund services need to understand and respect that uniqueness. "They now recognize New Concept as a professional organization providing relevant services, with a persistent voice for those concerns."

For more information about NCSDC, contact June Martin-Perry, executive director, 4828 W. Fon du Lac Ave., Milwaukee, WI 53216, 414/444-1952.

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a broad national initiative will accomplish this.

The Problem: A Focus on "Fixing" Rather than Development

Adults tend to think of kids ... you know ... they're just troublemakers ... put 'em somewhere, let 'em do something. It's like, ... a three-year-old, if they're messing with something, you're gonna throw 'em in a room just to play with a toy or something, just to get them out of the way.

—Washington, D.C., youth on WAMU-FM radio

The radio segment cited above reported on pending cuts in the summer youth jobs program of Washington, D.C. Like many youth who live in Washington, the boy quoted could be characterized as "high-risk." He is black, poor, and living in the inner city. For this reason, his comments and those of other youth interviewed are pertinent. During this interview, not one young person asked for a prevention or treatment program. Nor did one suggest the need to be "fixed" or "repaired." Instead they mentioned the need for opportunities to learn, observe, and contribute to the well-being of their neighborhoods.

Their responses raise a key question: Why do we, as policymakers, program directors, and citizens, believe that it is appropriate to cut summer youth jobs programs to pay for substance abuse treatment? Why do we accept the notion that it is logical to charge a fee for after-school recreation programs while offering free remedial education? Because we are locked into linear, one-track thinking that suggests that problems must be fixed before development can occur. The result of this thinking is that, often, services that promote youth development are pitted against those designed to forestall youth problems.

Our concern about youth problems has caused us to divide the population of young people into two groups: those who are "at risk" and those who are "okay." Many recent policy reports state that, in many ways, all youth are at risk. This is true, but the growing public and private commitment to targeting scarce resources means that someone will always ask, "Which youth are most at risk?" This is a critical question. Far too many young people are in family, school, and neighborhood environments that aggressively strangle their ability to grow and develop. These young people need extra supports. But linear thinking has led to the development not of extra supports, but different ones. What has developed is a very disjointed array of policies and services for youth.

At one extreme, there are policies and programs for "troubled" adolescents and young adults—court-involved youth; youth in foster care; emotionally disturbed, runaway, and homeless youth. These young people are quite likely to be clients of publicly funded programs that define youth needs in terms of placement, treatment, and case management. The programs and services focus on treating the child's problems. Indeed, youth are often eligible only if they demonstrate serious and extensive problems. At the other extreme, there is a rich array of services and supports available to children and youth deemed "problem-free." Frequently sponsored by community and private nonprofit organizations, these programs tend to impart some of the experiences necessary for adult success. Many are recreation and leadership programs that enhance teens' skills and help them achieve maturity and confidence. Often, they require fees. Too often, they do not accept or reach out to teens labelled as troubled.

In the middle there is precious little to help troubled or vulnerable youth move from receiving treatment and targeted problem-prevention services to exploring opportunities to develop the skills and traits essential to succeed as an adult.

Thinking that we have to fix problems before we can do anything to promote development means that we set priorities inappropriately. The public dollars allocated to youth are far too few, but those that do flow are disproportionately allocated to intervention, placement, and treatment for "high-risk" youth.

The debate in Congress, in city halls, and in town meetings becomes which problem to prioritize, which youth to define as eligible. As more attention is focused on youth problems, public and private dollars for the development of young people teetering just outside of these systems dwindle. Programs that reach youth in high-risk settings but do not limit their focus to reducing problem behaviors come to be viewed as beneficial but not essential. Ultimately, these programs—which most agree are the best of what are now called "prevention" or simply "youth" programs—are forced to accept funding which pushes them to provide fragmented, problem-focused programming at the expense of broader services and opportunities critical to problem-prevention.

The Solution: "Fixing" Through Development

The best way to help at-risk youth is to provide them with the same types of supports and services other adolescents need. It means engaging youth, their families, and their communities in developing the skills and potential of young people and in helping youth define and achieve their goals. In shaping those goals, it is equally important that we provide youth with evidence and examples of why risk-taking behaviors can inhibit or diminish their ambitions.

This approach is valuable for two reasons. It recognizes that we have created a bloated, vastly overextended system for crisis intervention and treatment while ignoring, to the detriment of all youth, primary supports that build competencies and prepare adolescents for adulthood. This approach also promotes a unified youth policy. Rather than stratifying and segregating at-risk and "problem-free" young people, it connects intervention, treatment, and prevention with development.

There is a large and growing number of programs and organizations across the country that work with young people in high-risk situations and are grounded firmly in a philosophy of development. The youth development philosophy, like the family support philosophy, is not codified. Definitions of best practice or good practice are shared in spirit but not necessarily in writing, standards are aspired to but are not regularly assessed, and programs and organizations that share the philosophy are not easily distinguishable from those that do not.

But the youth development philosophy, like the family support philosophy, builds on the basic premises of community, equality, respect, participation, and cultural competence. Compare, for

PROFILE

Rheedlen Centers for Children and Families: Total Community Involvement

Incorporated in 1970, Rheedlen was the first nonprofit organization in New York City to focus its attention on the problem of truancy among the young and to demonstrate the correlation between young children out of school and abuse and neglect. Rheedlen Centers for Children and Families deliver a wide range of primarily preventive services for minority, at-risk children and their families in four Manhattan neighborhoods (Central Harlem, East Harlem, Manhattan Valley, and Clinton), with the goal of ensuring that at-risk students stay in school and have an appropriate and meaningful education. The majority of those served by Rheedlen programs are African American families at the bottom of New York's economic strata.

Rheedlen strives to keep families intact, to provide supplementary educational instruction and professional social services, to create healthier neighborhoods, and to develop a countervailing force in communities where there is an increasingly powerful drug subculture.

Rheedlen emphasizes the importance of education, and all its programs—including recreational ones—include some academic component. Rheedlen provides community-based services and preventive services in seven distinct programs. These include:

- **Truancy Prevention Program**—Rheedlen's first program, this serves as a model for its others. A staff of social workers identifies cases of abuse and neglect and cases that have the potential for abuse and neglect, contacts the family, and enrolls the child in the program. Staff provide tutoring in reading and math as well as dance, drama, and arts and crafts. Social workers work directly with the public schools, the New York Child Welfare Agency, and Rheedlen.

- **Rheedlen Dropout Prevention Programs**—Operated in four elementary and junior high schools, these programs provide case monitoring, home visits, crisis intervention, tutoring, recreational programs, field trips, and special events. Rheedlen is working directly with the board of education on this effort.

- **Center 54**—This community center in Manhattan is open from 3:00 to 10:00 P.M. five days a week, seven months of the year, and until 6:00 P.M. the other five months. The center offers a wide range of services to all ethnic groups. All children must be involved in the academic component of the center.

- **Parents Help Center**—The Center was established to provide referred parents with preventive services and a chance to talk with one another about the issues and problems surrounding raising children without enough money, often in substandard housing, and often with no support from other people. The Center also offers individual tutoring to children, a clothing distribution program, and free food to the residents of the community.

- **Project Motivation**—The Project provides prevention services to the community from a local school. It offers case management, counseling, emergency clothing and food distribution, after-school tutoring and recreation, and crisis intervention.

- **Rheedlen Place**—Rheedlen Place addresses children's reaction to possible homelessness. The project provides social services, after-school programs, recreational activities, parenting skills training, crisis intervention, and escort services for neighborhood safety.

- **Neighborhood Gold**—This program provides intensive, short-term social and educational services to formerly homeless families to ensure that they do not become homeless again. Eligible families receive counseling, advocacy services, and after-school programs for children.

Each year, Rheedlen looks for areas in which to improve its programs and strengthens services to meet the diverse needs of its clients. It is this tangible commitment to providing effective, quality programs that makes Rheedlen a successful and respected force in the community.

Staff Commitment to the Community

The Rheedlen staff of 52 full-time, 56 part-time, and 13 community and private-sector volunteers consists of social workers, teachers, activity specialists, and program aides. Most are African American and live in the community. This is not accidental. Rheedlen recognized that the continuous message to youth was, "If you make it, you should run from the neighborhood as quick as you can." The adults associated with Rheedlen demonstrate to young people that it is possible and desirable to be a decent, hardworking man or woman living your life in the neighborhood. Rheedlen views all staff as "living models." Thus, everyone from social workers to administrative support staff and custodial workers are considered central images for young people.

Staff go beyond work in the centers. Total community involvement has meant taking children to medical appointments, escorting youth to Rheedlen for after-school tutoring, and putting parents in touch with other community-based agencies for additional support and vocational services. Additionally, social workers and program directors are advocates for community residents; they get involved in housing issues, public schools, community parks and playgrounds, and emergency food and clothing distribution.

Rheedlen emphasizes the importance of staff/participant relationships and hires staff who enjoy being with and working with children and their parents. Many Rheedlen staff stay with the program six to 10 years. The strong personal relationships and trust that exist between the staff and the community have and will continue to be central to Rheedlen's growth and success.

For more information about Rheedlen, contact Geoffrey Canada, executive director, at 2770 Broadway, New York, NY 10025, 212/866-0700.

example, the principles articulated by the Family Resource Coalition with those articulated by the National Network of Runaway and Youth Services *(below)*.

National Network of Runaway and Youth Services: Guiding Principles

- Valuing youth
- Empowering youth
- Strengthening families
- Promoting healthy alternatives
- Supporting diversity
- Encouraging community-based services
- Networking

Not all of the nonprofits that work with youth in high-risk situations espouse principles such as those articulated by the National Network and Runaway and Youth Services, and of those that do, not all consistently put these principles into practice. But there are many that do practice these principles as they work with youth—teen parents, dropouts, and unemployed youth, abused and runaway youth, court-involved youth, gang affected youth. The philosophy, operational flexibility, and commitment of these organizations makes them prime candidates for becoming critical resources for youth whose needs have not been adequately met at home or in school.

The following three examples are just a few of the many programs widely recognized by practitioners and program planners as exemplary. They range from a large multi-service agency to an alternative school for youth with emotional and behavioral problems. While clearly different in the services they offer, all three programs emphasize a development-focused strategy which respects and promotes the potential and competence of youth.

• The Door, a Center of Alternatives

Right now I feel like The Door is where I'm learning to fly.

—Linda, 19

When we give [teens] successful experiences, for instance in the arts, their self-definition becomes, "I'm the person who just accomplished such-and-such. Yeah, I may have a problem at home or in school, but that's not all I am." We don't label kids, and they don't feel like a walking problem when they come here.

—Ophie Franklin
Former Executive Director

The Door, A Center for Alternatives, has created a unique environment for young people which is intentionally youth-centered. Founded in 1972 by the International Center for Integrative Studies (ICIS), the Door was established to meet the needs of New York City's neediest young people and to test the effectiveness of providing several services in an integrated way. Today it is the most comprehensive cultural, mental health, vocational, education, and health center in the United States, drawing 6,000 teenagers annually. While most of these youth are poor and disadvantaged, any young person may use the more than 30 coordinated services and programs.

Aside from its impressive reach and size, the Door is distinctive in the opportunities it provides and the way in which it provides them. It is a walk-in, no-fee source for help. Services are integrated through collaborative planning and program development. With the assistance of a large cadre of volunteers, the Door offers comprehensive services that include medical care and legal consultation, drug rehabilitation, employment aid, meals, and classes that range from martial arts to English. Young people interact with a host of professionals within a single facility—physicians, lawyers, teachers, job developers, counselors, nutritionists, athletic coaches, and artists. Indeed, the key to the Door is complete coordination of services with interdisciplinary staff supervision at all times. Each staff member is alert to the many issues a youth may face and strives to treat the whole person. Every doctor, lawyer, and teacher at the Door, including the wrestling coach and pottery instructor, is a trained counselor.

• YouthBuild USA

Leadership can engage young people intensely and deeply, liberating their best energies.

—Dorothy Stoneman
President

YouthBuild USA was first developed by the Youth Action Program of the East Harlem Block Nursery. The Youth Action Program was established in 1978 to work with youth in designing and implementing community improvement projects. These projects have included rehabilitating housing, constructing parks, reclaiming two community centers, crime prevention patrols, and creating residences for homeless youth.

In 1988, the founder of the Youth Action Program, Dorothy Stoneman, established YouthBuild, with Boston slated as the first of several sites. YouthBuild trains young people 17 to 24 to rehabilitate abandoned buildings to accommodate low-income and homeless people. Participants engage in general construction work and learn basic carpentry, electrical, and plumbing skills. Academic and vocational skills are imparted through an education (GED) and vocational training program lasting one year. YouthBuild also offers counseling, academic classes, and recreational and cultural activities.

Critical to YouthBuild's operation is its emphasis on leadership. The organization believes that many young people are impoverished and powerless. They live in a society that, although affluent and greatly influenced by power and wealth, fails to accord youth respect or opportunities to participate or contribute. Furthermore, it has failed to protect most young people from drugs and violence. For this reason, YouthBuild teaches skills in decision-making, speaking, facilitating groups, and negotiating.

YouthBuild has been written into federal law in the National Youth and Community Service Act, and $8 million has been authorized for YouthBuild programs to be administered by ACTION. In addition to Boston, there are

YouthBuild sites in Tallahassee, Cleveland, San Francisco, and three in New York City. Several more will be established in the coming year.

• City Lights

To me success is when I see a kid walk in here and they can hold their head up and say, "I'm worth something" ... The expectations that they hold themselves to become higher.

—Robin Keys,
Caseworker
The Washington Post,
Oct. 1988

An important underlying principle of our day treatment program is the belief that education is therapeutic and therapy is education; therefore the boundary between these two program components is intentionally blurred.

—Judith Tolmach Silber
Founding Director

I'm just trying to work hard to get up there ... Being as I ain't been to school in five years, it's kind of exciting doing the work.

—Lena, 20, speaking about her efforts to move up from an eighth-grade academic level

City Lights gets its name from a 1931 Charlie Chaplin movie about a victimized man's struggle to survive and to foster love for a flower girl. City Lights evolved from a class action suit against the District of Columbia Department of Human Services for not providing sufficient community-based treatment for adolescents in the city's custody.

Recognized as a "best-practice" model for mental health care, City Lights is an unusual day treatment program that links therapy with classroom instruction. Pivotal to the operation are intensive personal attention and a supportive network of teachers, counselors, and peers. The youth face multiple problems, often including emotional, behavioral, educational, and vocational difficulties. They are taught but they are also prepared for work and life through a tripartite approach consist of academics, counseling, and vocational training and placement. Students advance at their own pace, learning not only academic skills but life skills such as budgeting and nutrition. Students also receive a variety of types of counseling, including individual and group therapy, family counseling, music and art therapy, and substance abuse prevention and treatment.

STANDING APART FROM THE OTHERS

Programs that are explicitly committed to helping young people build the full range of necessary competencies and meet the needs so critical to the development of confidence and commitment to others stand apart from those designed to simply fix problems. Dorothy Stoneman, President of YouthBuild, says programs must offer youth:

- profound respect
- power over their immediate environment
- protection from disaster
- meaningful and important work
- real, patient caring for their development
- actual teaching of skills
- consistently positive values
- family-like support and appreciation from peers and adults
- understanding of the proud and unique history of their people
- a path to future opportunity
- real concern and action from the agency about changing the conditions that have affected them and the people they love.

Despite their apparent differences, The Door, YouthBuild U.S.A., and City Lights demonstrate that youth development is a philosophy which can be applied to many different programs and services. Equally important, they exemplify how the goal of youth **development** can successfully serve youth labelled as "at-risk" and viewed as primarily in need of **treatment**. Dozens of other examples can be offered. Some, like the Shiloh Baptist Church Male Youth Project, in Washington D.C., are sponsored by religious organizations. Others, like Fifth Ward Enrichment Program in Houston, Texas, are offered in school during the school day. Still others, like Midnight Basketball League in Chicago, are sponsored by the housing authority.

Schools, religious organizations, housing and community development organizations, direct service nonprofits, and businesses exist in almost all communities. Insufficient attention has been paid to identifying and developing their combined capacity to offer young people the opportunities, structures, and concrete supports and services they need to bring purpose to their present lives as they prepare for their futures.

Moving the Vision

We know what is needed. What works, for all types of youth, in all types of communities, is sustained and demonstrated commitment to helping youth set and achieve positive, meaningful goals. Our commitment cannot be naive—many young people have real problems and face grave risks. These must be addressed. But we must make a full commitment to every youth in this country. As soon as we suggest that the most we expect from a significant proportion of our youth is that they become "problem-free," we have

undermined our ability to gain their attention and their respect. We have given them permission to turn elsewhere for structure and standards.

Youth Development and Family Support

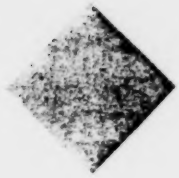
The grounding premises behind the youth development movement are clearly not only compatible with but almost identical to those of the family support movement. Connecting the language and goals of these two movements can only strengthen each.

Equally important and more difficult to address, however, is the need to connect the programs. Adolescence is a time of separation—emotional, physical, and relational. There is no doubt that programs working with adolescents, especially older adolescents, have to balance the need to work with youth in a way that reinforces their growing needs for participation, recognition, and skill-building with the need to work with parents. Family support programs have been more successful at reaching families with young children than at working with those with adolescents (the exception being when the teen is the parent). And youth development programs vary enormously in their commitment to working with youth in the context of family. When youth development programs see families as an asset, they are likely to seek families' involvement. When they see families as needing supports and services as much as young people do, rightly or wrongly, programs often feel that allocating resources to working with families drains their capacity to work with youth.

Again, there are exceptions. The Rheedlen Centers for Children and Families in New York City, the New Concept Self-Development Center in Milwaukee, and the Carole Robertson Center for Learning, in Chicago, are three examples of organizations dedicated to working with children and families in communities that have made special commitments to engage adolescents and to continue to work with families of adolescents.

There is a very real need to create a table around which those whose primary focus has been family support and those whose primary focus has been youth development can sit with those who have tried to balance both. The Center for Youth Development is committed to making this happen, as is the Family Resource Coalition. This article is just the first of many steps that can and will be taken to make youth development and family support conceptual and programmatic partners.

Karen Johnson Pittman is a senior vice president of the Academy for Educational Development and the founder and director of the Center for Youth Development and Policy Research, which is housed within AED. The Center, founded in 1990, is working with funders, policymakers, organizations, and communities across the country in an effort to redefine goals, expectations, and roles for youth. She recently became a member of the board of directors of the Family Resource Coalition. Prior to creating the Center for Youth Development and Policy Research, she was the director of the Children's Defense Fund's Adolescent Pregnancy Prevention and Policy Division. This article is based on testimony delivered by her in September, 1991.



Section V: Supporting People with Disabilities

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OVERVIEW

Components of a Comprehensive Family Support System for Families of People with Disabilities

by John Agosta

Throughout the country, most people with developmental disabilities live at home with their families, especially during the early stages of life. This fact, coupled with the nation's improving regard for the well-being of families, prompts concern for assuring that these people receive the services they need, and that their families' efforts are supported. Over the past 20 years, this concern has stimulated the development of several initiatives to support families who provide care at home to individuals with disabilities.

Pennsylvania developed one of the first family support programs for children with mental retardation in the country in 1972. Since then, more than 40 states have joined in.[1] Complementing these programs, states have also begun to use other sources of support for families, such as informal community supports, and to weave these multiple stores into a cohesive response to family needs. While family support is not yet the "law of the land," the idea continues to gain momentum, as well as needed political and financial backing.

What Is Family Support?

Family support means different things to different families. For families of people with disabilities, the idea is simply to provide them with whatever it takes for them to live as much like other families as possible. Actions to develop a response to families should be guided by a series of goals to reflect what might be achieved and principles to articulate the philosophy that should underlie the supports offered. And to assure that these goals and principles guide the system, families must be placed in an oversight position to help set and evaluate family support policy and practice.

Program Goals

Turnbull, Garlow, and Barber articulate four goals related to family support:[2]

- to prevent unnecessary or unwanted out-of-home placement
- to enhance the family's capacity to provide care
- to merge formal and informal helping networks around families
- to utilize available public dollars most efficiently.

Underlying Principles

There is a clear need for some set of "framework principles" to be articulated at the state level to guide the design and delivery of services. These principles can be used to set—in broad terms—the standards and expectations that should characterize program efforts statewide. In recent years, numerous sets of "family support principles" have been distributed. Dunst, Trivette, and Thompson provide an analysis of these principles by sorting them into six categories; those that:[3]

1. enhance the sense of community
2. mobilize resources and supports
3. emphasize shared responsibility and collaboration

PROFILE

Helping Families Face Long-Term Special Care

Hood Center for Family Support
at the Dartmouth Medical School
Hanover, New Hampshire

by George H. S. Singer

The Hood Center for Family Support is a research, training, and policy analysis center at the Dartmouth Medical School. Its mission is to enhance the capacity of families to support family members with special health care needs in a way that maximizes the well-being and self-determination of all family members.

The Center is designed to respond to the revolutionary changes that medical and technological progress is making in the nature of childhood illness and disability. In the last two decades many of the diseases and injuries that used to cause death in childhood have become chronic conditions. Many childhood cancers that used to be fatal are now long-term illnesses. The life span has doubled for children with cystic fibrosis, and recent medical advances promise further improvements in longevity.

The treatment of head injuries has advanced dramatically with the creation of new trauma centers, medications to reduce brain swelling, new technologies for imaging the brain, and improved surgical procedures. Similarly, advances in the treatment of premature infants have led to the survival of babies who were routinely expected to die in the recent past. In each of these examples, children no longer inevitably die of disease; instead, they live with chronic conditions that require long-term special care. This care poses major challenges to their families. Parents, grandparents, and siblings provide the main day-to-day support for these children.

Currently medical and social systems deal primarily with acute illness. Only recently have community supports begun to allow families to live normal lives while they support family members with long-term illnesses or disabilities. Because of the dearth of supportive communities and cultural practices, many family members—especially mothers—experience high stress and become demoralized. The demands placed on care-giving families are made much more difficult by poverty; poor children with chronic illness are at high risk of having long-term social and emotional problems. But families can be highly resilient, and when given sufficient support they take care-giving in stride, learn, and benefit from the experience. The Hood Center focuses on identifying these supportive practices, testing them with well-designed research, and assisting policymakers in adopting them.

At the present time the Hood Center is carrying out five model demonstration or research projects, one of the which is the New Hampshire Partners in Health Project, a cooperative venture with the New Hampshire Department of Health and Human Services and several local health care and educational organizations. This model demonstration project provides services for families of children with special health care needs in three communities in New Hampshire through seven components:

- Family councils that provide governance and advice
- Family support coordinators who provide family-centered case management
- School teams that develop individual health care plans
- Technical assistance to community-based physicians on caring for children with special health care needs
- Respite care for families
- Office-based technical assistance to make community medical practices more responsive to families of children with special health care needs
- A statewide task force appointed by the governor to recommend policies for supporting families of children with chronic illness

The Partners in Health Project is funded by a grant from the Robert Wood Johnson Foundation and the State of New Hampshire. The project is in its first of three years; in the third year staff will produce manuals and videos to assist other states and communities in replicating the model. The principal investigators on the Partners in Health Project are George Singer, Ph.D.; Laurie Powers, Ph.D.; Ardis Olson, M.D.; Carl Cooley, M.D.; and Kathy Sgambati, MSW.

Helping teenagers with special health care needs develop a sense of self-determination is the focus of two other major projects at the Hood Center for Family Support. Laurie Powers' detailed curriculum and set of learning experiences teach adolescents to set goals, identify obstacles and plan ways to overcome them, and seek and manage support from others. A mentoring program brings teenagers with special health care needs together with successful adults who have similar health conditions or disabilities. Dr. Powers' evaluative research shows dramatic changes in the behavior of teenagers who participate.

The Hood Center directors have recently published a book on family support for families of persons with disabilities. In cooperation with the Beach Center on Families and Disability, the Center will edit a series of books for Paul Brookes Publishing Company on families, community, and disability. Other products of the Center include videotapes, reports, and data-based research articles.

George H. S. Singer, Ph.D., is director of the Hood Center for Family Support, and is an associate professor of pediatrics at the Dartmouth Medical School.

4. protect family integrity

5. call for supports to strengthen family functioning

6. emphasize certain preferred human service practices.

Effective family support systems recognize that families play a vital, if not leading, role in the decision-making process. New Hampshire is one example of a state that genuinely involves families in family support–related decision-making. As a result of the state's 1990 family support legislation (Senate Bill 195), regional councils, composed primarily of family members, have great sway over the design and operation of the state's family support programs.[4] Several other states (e.g., Colorado, Oregon, Vermont, West Virginia) are following this pattern states by establishing local advisory or governing boards run by family members who represent the full range of people served by the program.

Family Support Should...

- **Focus on the entire family**
- **Change as the family's needs, roles, and ages change**
- **Encourage families to express their own needs and direct decisions on how their needs are met**
- **Treat people with disabilities and their families with dignity by respecting their individual choices and preferences**
- **Respect cultural, economic, social, and spiritual differences**
- **Encourage families to use the natural community resources**
- **Provide a convenient and central access to services and resources**

—Human Services Research Institute, 1993

Essential Program Features

The challenge in determining essential program features is to establish practices that are consistent with the stated purposes and principles. Both procedures for determining eligibility and selecting families into the program and actual service practices must be family-focused and flexible, must make use of existing community resources, and must demonstrate meaningful effects. Above all, program actions must minimize the cost, financial and otherwise, to families for seeking and acquiring the support they need.

• Eligibility and Selection

Current eligibility criteria are typically tied to the diagnostic condition (e.g., mental retardation, developmental disability) experienced by the family member with a disability. In addition, states may also impose other criteria, such as the age of the person with a disability, family income, or risk of out-of-home placement. But determining initial eligibility is only half of the story. Once found eligible, families must be selected into the program. Because the demand for services exceeds available resources, family support programs are typically confronted with a rather wicked administrative issue: how to decide which families to serve. The dilemma is often resolved by trying to serve those "most in need" or by limiting the amount of help a family can receive based on the extent of their need.

A needs-based approach is at first appealing, given that it makes a small number of resources go far. Yet from the outset it can undermine the basis of the program. When help is portioned on the basis of need, power is lifted from the family and placed with the program. Inevitably, families must demonstrate their "dysfunction" to the maximum extent so that they might outdo other families who are not found as needy. The process is not at all satisfactory to those seeking help, since it can be a painful experience, one in which the value of one's needs is being judged and compared against that of other families.

An alternative approach involves a process of random selection, a lottery, in which all those who apply have an equal chance of gaining admittance. But as equitable as this approach may seem, critics point out its obvious shortcoming: those most in need may not be selected, and so go without the supports they desperately need.

Colorado may have recently come upon a reasonable compromise. The state divides its family support resources into four programs that complement each other. The first offers ongoing support to those most in need. The second program offers time-limited support of one year to randomly selected families. The third program offers temporary respite care on an as-needed basis, given availability of funds. The final program consists of special reserve funding that may be accessed in times of emergency. While not perfect, the Colorado programs attempt to accommodate those most in need, while still offering hope to the many families who can use a helping hand now and again.

• Family Focus and Flexibility

The most obvious significance of "family-focused" supports is that the person with the disability is seen not in isolation but as part of a whole family. The intent of the program is to push beyond the needs of the individual, strengthening the entire family. The supports offered must be available to all family members, a concept that departs significantly from previous practice, which focused exclusively on the person with a disability. In addition, the family must be enabled and empowered to identify its own needs and to direct how those needs will be addressed; families must be placed in control of the supports they receive.

Within this context, there is a growing awareness that family support should not be restricted to just a few services (e.g., respite care), but must offer an array of options to families.[5] The best programs balance core support services with some type of cash assistance.

• Using Community Resources

Because it has become clear that the resources available within the public support system are too limited to meet the full range of family need, and because supports are believed to be most effective and least costly when their source is closest to the family, both

PROFILE

Keeping Families Together

Seneca Mental Health/
Mental Retardation Council, Inc.
Lewisburg, West Virginia

by Mary Ann Shires

Seneca Mental Health/Mental Retardation Council, Inc. (SMH/MRC), a rural four-county mental health center, is committed to providing care for people with developmental disabilities within their own environments. Individuals benefit by growing up with their families, families benefit by being together, and communities benefit from the inclusion of people with diverse abilities.

SMH/MRC recognizes that as rewarding and satisfying as it may be to raise a family member with developmental disabilities at home, emotional, social, physical, and economic stress often occurs. Natural supports from programs, extended families, friends, and the community are never enough to supply all the specialized goods and services required.

Said a mother whose 13-year-old child has cerebral palsy, "Their support, referrals to other services, and stipend have allowed me to modify our home so I can assist her in remaining healthy and happy. Without family support, my daughter, who is medically fragile, would have to live elsewhere."

In 1991, West Virginia legislated a Family Support Program, which paved the way for programs to support families providing in-home care to members with disabilities. The legislation put in place a coordinator and an advisory group of parents in the state (the State Family Support Council), and allocated money for local family support programs to grant families "last-resort" funding. SMH/MRC applied to the West Virginia Office of Behavioral Health and the West Virginia Disabilities Planning Council to begin a family support program and was approved.

All families participating in SMH/MRC's family support program receive at least assistance in obtaining and coordinating services. Cash stipends are granted only if other sources can't be found, however, most families have received them for respite care; health needs; architectural and vehicular modifications; specialized equipment and supplies; utilities; and transportation.

Persons with disabilities, parents, and care providers in the Seneca area specified from the beginning that the family support program's services should be individualized, flexible, family-centered, accessible, and easy to utilize. To make the most of this approach, eligibility requirements are kept simple.

1. Each family, natural or foster, and each caregiver served must provide in-home care to an individual who meets the federal definition of developmental disability.

2. Individuals served must reside in SMH/MRC's catchment area.

3. The stipends for goods are "last resort" funding.

The program's staff consists of a family support coordinator and a service coordinator. This staff is overseen by a regional nine-member council that consists mostly of persons with disabilities, parents of persons with disabilities, and care providers. This council collaborates with SMH/MRC on matters related to local implementation of the stateFamily Support Program and communicates information and recommendations regarding this program to the State Family Support Council. The regional council oversees applications and assessment procedures, selection of program participants, allocation of funds, and program and council evaluation and requirements. It reviews all families' requests for funding and issues checks directly to families, and it participates in the development and continuous review of the program's policies and procedures.

The family support program administered by SMH/MRC has provided services to approximately 300 families in its three-year history; many of these families had more than one individual with a developmental disability. At least 80 percent of the program's yearly funds are distributed directly to families for the goods and services they need. In addition, the family support program connects families with the state rehabilitation office, local religious groups, and organizations such as sororities and fraternities who provide volunteer labor. The program's network of resources includes local individuals and businesses who donate materials to families in need. With the help of this program, families' needs that have in the past been out of reach are now dreams come true.

Mary Ann Shires, ACSW, LCSW, is family support coordinator and early intervention coordinator at Seneca Mental Health/Mental Retardation Council, Inc., and is a former genetic counselor. She can be contacted c/o Seneca Mental Health/Mental Retardation Council, Inc., 100 Church Street, Lewisburg, WV 24901, 304/645-3319.

geographically and personally, there is growing interest in utilizing existing informal or "natural" supports to assist families. At the most personal level, neighbors, friends, coworkers, and relatives might be called upon to provide support. At the community level, a variety of resources, such as those available through churches, day-care centers, and private employers can provide useful support. Relying on existing community resources represents a departure from previous service structures, which encouraged reliance on formal service programs rather than using existing support networks.

• Demonstrating Program Effects

Recent evaluations of family support services suggest that the programs do have a positive effect on participating families. Families receiving services report, among other things: (a) enhanced commitment to continued care at home rather than out-of-home; (b) improved capacity to keep up with household routines, pursue hobbies, and seek employment outside the home; (c) improved skills for coping with habilitative needs; and (d) improved overall quality of life.[6]

Regarding system effects, early arguments for family support were often based on cost-effectiveness, since family support would preclude expensive out-of-home placements. But until recently that claim was arguable, since most families choose to keep their children home with or without support.

From 1980 to 1990, however, Minnesota's family support effort yielded impressive savings to the state in relation to the number of children served.[7] In 1980 the state was serving 50 families through a subsidy program and 830 children out-of-home. Policies enacted since then have resulted in dramatic shifts in these numbers. Over the 10-year period, the number of children living out-of-home was reduced from 830 to 291, the number of families served was increased from 50 to 1,827, and the amount spent increased from $20.4 million to just $24.3 million. This amounts to a 240-percent increase in families served, with an increase of only 20 percent in spending. In fact, the analysis also shows that if the state had not changed its policies and had instead continued its service strategies, the cost of serving the same 880 families and children would have increased from $20.4 million in 1980 to $44.3 million in 1990!

Three Emerging Issues

In recent years progress has been made toward establishing comprehensive systems of family supports. But there is still much for us all to do. Important issues facing family support proponents revolve around three needs:

- to assure the continued involvement of families in shaping public policy and local practice
- to secure sufficient funding for family support
- to promote cohesive family policy through system collaboration.

• Family Involvement

Family members have worked hard to educate policymakers across the country on family support issues, and have enjoyed early success. But as these embryonic efforts mature, there is concern that the resulting innovative practices will turn stale in the face of a need to routinize and regulate services. The local family support councils in several states will help to offset this possibility. But special effort must be exerted continually to ensure that these council members are prepared to make informed choices concerning the direction and substance of local practices. Where such investment is lacking, over time family members will be hard pressed to influence the very system they worked to create.

• Sufficient Funding

Forty years ago the demand for services and state financial resources were channeled primarily into an extensive system of large residential facilities, with relatively little complementary investment in families. Over the past 25 years, however, the institutional response to disability has given way to a community-centered system that offers a range of day and residential options. Institutions are closing their doors as community systems are expanding.

Yet while much has changed within the developmental disabilities system, for most families there has been little or no change. Millions of dollars are still spent on out-of-home services, and relatively little money is invested in families.[8] While more than 40 states report the presence of at least one family support program, these programs generally serve relatively few families. A system of family supports cannot be truly comprehensive if it is limited to a small number of families or is unavailable in some regions of a state. Though some states such as Michigan and Wisconsin can point to a few fairly comprehensive efforts, the ideal of an equitable statewide system has not yet been fully realized anywhere.

• Collaboration and Family Policy

Evidence regarding family support nationwide clearly indicates that the needs of many families cannot be met by one government authority (education system, developmental disabilities, or Medicaid). As a result, families often are challenged to negotiate multiple agencies at once, a frustrating task made more so when the policies of one agency conflict with those of another. Most would now agree that family support systems have their greatest chance for success when state agency officials work together. This point is made even more salient when today's concerns over state budgets are taken into account. No single state agency should be counted on to configure and administer a comprehensive family support program on its own. An effective response that takes full advantage of all available state resources will require interagency teamwork.

Across the nation, states have begun to react to the necessity for collaboration, albeit slowly and without dramatic widespread effect. Even while states begin to sponsor multiple efforts to support families, programs too often operate independently and without any apparent tie to principles or objectives that would blend these resources into a single response to families. As a result, while the current times call for collaborative effort and efficient teamwork, states typically find their family-directed resources scattered and unfocused.[9]

Facing the Challenge

The challenge posed by the need for a family-supportive response to disability is not modest. What is called for is not a simple response involving mechanistic or subtle shifts in state systems that can be dictated from the top and easily implemented across the state. Continued progress toward a family-centered

PROFILE

Inspiring Home Visiting Programs Around the Country

Portage Project
Portage, Wisconsin

The Portage Project is a home visiting program that collaborates with community agencies to provide comprehensive services to families of young children with developmental disabilities. It also serves children with conditions that will probably result in developmental delays. Established in 1969, the Project recently developed and began implementing a special Birth to Three program, and it also now publishes resources for other communities to use in forming Birth to Three collaborations.

Parents either refer themselves or are referred to the Portage Project—Birth to Three by other agencies. A multidisciplinary team visits the family at home and conducts a play-based assessment, observing parent-child interaction patterns, parent perceptions, and the developmental functioning level of the child. If the team, including the parents, decides that the child is eligible for Birth to Three, they start formulating an Individual Family Service Plan, which might include weekly home visits by a member of the Portage Project transdisciplinary staff, therapy or counseling from providers in the community, consultation with day-care or other caregivers, participation in parent or play groups, or other activities that the family requests. One interventionist serves as care coordinator for the family and stays in touch with all the family's service providers. As part of its community-based activities, the Project coordinates community-wide meetings of practitioners and families to insure communication among all parties and to promote collaboration and coordination of services.

If home visiting is part of the Individual Family Service Plan, a home visitor (usually a teacher by training) makes weekly 90-minute visits with the family. During this time the visitor helps the family create strategies based on the family's everyday life for addressing the child's needs as they have been assessed. The visitor also helps the family develop their support network, make plans to address broader family concerns, and access community resources.

The Portage Project recently published a set of materials called *Growing: Birth to Three*, which resulted from extensive research and more than 30 years' experience on the part of the family-centered interventionists who wrote it. *Growing: Birth to Three* strives to meld a set of family-guided interventions into a seamless whole that facilitates interaction, is built on daily routines, and recognizes the importance of environment and community. The four main principles of *Growing* reflect the principles that guide the Portage Project's Birth to Three program:

1. Intervention is guided by the family.

2. Parent-child interactions are the heart of early intervention.

3. Family rituals, daily routines, and play reflect the patterns of family life and are the medium into which intervention is embedded.

4. Recorded ongoing observations and conversations between parents and interventionist are the basis for intervention decisions.

These Birth to Three materials supplement the Project's previously published body of literature, available in 30 languages, which helps families chart and encourage development in five areas: cognitive, linguistic, self-help, motor, and socialization.

A 1972 federal grant enabled the Portage Project to replicate in 30 sites, and to become a regional training site for home-based Head Start programs.

For more information about the Portage Project—Birth to Three, write CESA 5, 626 East Slifer St., Portage, WI 53901, or call 608/742-8811.

response to disability must be achieved despite significant concern over public spending and historical patterns for delivering services that may inhibit development of the system we envision. To succeed, people with disabilities, family members, service agency staff, state officials, others involved in the lives of people with disabilities—all those who have a stake in the outcome—must work together.

To fully realize the promise for families that has been set in motion over the past several years, we must face our challenge head-on. In this decade policymakers must build upon recent successes, yet must press forward to implement means for coordinating all available resources on behalf of families while maintaining the family focus and flexibility that characterizes present best practice.

John Agosta, Ph.D., is a senior research associate at the Human Services Research Institute and has worked with people with disabilities for nearly 20 years. Employed at HSRI since 1983, Dr. Agosta has been involved with nearly all its efforts surrounding family support issues. He has written extensively concerning issues such as cash assistance, has provided technical assistance to states establishing family support programs, has evaluated pilot programs in three states, and has worked with families in numerous other states to articulate their vision and to educate policymakers about family support issues. Dr. Agosta can be contacted by writing HSRI 525 Glen Creek Road NW (#230), Salem, OR 97304 or calling 503/362-5682.

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OVERVIEW

A LIVING WAGE AND A HEALTHY FAMILY:

Taking a Two-Generation Approach to Welfare Reform

by Susan Blank

Section VI: The Welfare System

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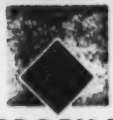
As the latest round of welfare reform proposals moves to the top of the nation's policy agenda, discussions will inevitably conjure up images of the "typical welfare recipient." Some Americans will envision that individual as an African American single mother; others will know that recipients are more likely to be white. There will be controversy about whether the typical recipient stays on public assistance for a long or a short time and whether she passively waits for a welfare check or is willing to work. But with two-thirds of the welfare caseload under 18 years of age, the typical person who depends on welfare is neither an African American woman nor a white woman nor a woman living in an inner-city neighborhood, but a child. Furthermore, given the multiple risks associated with the poverty levels that determine eligibility for Aid to Families with Dependent Children (AFDC), that child is likely to be among the most vulnerable in our society.

On one level, Americans who are at all familiar with the welfare system recognize that people depending on public assistance are most likely to be children. They know, for example, that to receive benefits under AFDC, the nation's largest cash benefit program, a household must contain a dependent child.

But when welfare policy is formulated, children somehow recede into the background. Consider, for example, current conceptions of the mission of the welfare system. Policymakers and political leaders have called for a shift of the welfare system's mission from "check-writing" to "employability development." Although those goals have merit, the welfare system can be oriented to either of them and still pay little or no attention to many pressing needs of the children it serves. Certainly, the "check-writing" mission ensures basic support in the form of income for children, while the "employability development" mission increases the likelihood that parents eventually will be in a stronger position to provide that support on their own. But it is possible to pursue income maintenance or welfare-to-work without ever taking into consideration the full range of circumstances of the AFDC family. The system may never know, for example, that the family has a developmentally delayed child, or that there is a history of domestic violence, or that the toddler has never been given a full preventive health examination.

Indeed, concentrating on a circumscribed set of issues—originally income maintenance, supplemented more recently by a focus on work and training—has characterized our welfare system ever since the 1960s. Many would argue that this specialization makes sense because given the system's limited resources, it is unfair to expect state welfare programs to reach beyond their new employability-development mission to meet other family needs.

But as report after report underscores the inefficiency and ineffectiveness of fragmented responses to the problems of at-risk children and families,[1] it becomes important to ask whether the welfare system's specialization means isolation, and if so, what are the consequences of



PROFILE

IOWA's FaDSS:

Welfare Reform Based on Family Support Principles

In 1987, the Iowa General Assembly established the Family Development and Self-Sufficiency (FaDSS) grant program, a welfare reform initiative embodying family support principles. The legislation was based upon the belief that families bring more than employment needs into the welfare office. Research indicated that families at risk of long-term welfare dependency were families whose children were least likely to start school ready to learn and most likely to become involved with the child welfare and foster care system. By taking a long-term, developmental approach with these families, FaDSS has sought to improve family self-sufficiency and child well-being in a broad context that includes, but extends beyond, welfare-to-work.

Currently, there are 11 FaDSS grantees in Iowa operating programs at 31 sites, including the flagship FaDSS site operated by Mid-Iowa Community Action (MICA). While highly regarded in the state, FaDSS remains a demonstration program and serves only a little more than 1,000 of the more than 30,000 Iowa AFDC families.

On November 9, 1993, Sis Vogel testified about FaDSS in Memphis, Tennessee, before the Clinton administration's Working Group on Welfare Reform, Family Support, and Independence. Her testimony is provided below.

During my tenure as a FaDSS Family Development Specialist with Mid-Iowa Community Action, known as MICA, I have worked with 37 families including my current caseload (I now work half-time and carry a caseload of 12 families). Thirteen of those families have been successful in moving off of Aid to Families with Dependent Children and I project success for the current families.

The MICA FaDSS grant dictates that we work with families of all ages who have been in the welfare system two years and longer. These are the families we believe to be at risk of long-term welfare dependency. Due to this category, we expected to find participating families who experienced a number of major life barriers. The actual percentage of families facing numerous barriers was substantially greater than our projection. A report reflecting those numbers has been provided to you.

Reporting such as this is necessary in our work. However, we do not view our caseloads as numbers or percentages, but as families. These families are made up of Mom, her children, and in many cases Mom's significant other. Each family member has his or her own needs to be met and dreams for the future.

My role is to join in a partnership of trust with each individual family member and with the family as a unit to assess their needs, explore their vision, assist them in setting and achieving realistic goals to fulfill their vision and link them with their larger community while offering support and advocacy throughout the process. The majority of this takes place during visits with the families in their own homes.

We offer what the families themselves have told us they need but have not experienced within the welfare system or elsewhere. Those needs are respect, healing, and opportunity.

In witness to the validity of their stated needs, I offer you the following brief examples of my work with actual FaDSS families:

A Cambodian women spent nearly six hours pacing the floor while relating to me the chronological details of her experiences of horror at the hands of the Khmer Rouge, her flight with her husband and family to the U.S., and her subsequent divorce. Her dialogue was punctuated at intervals with the words "I need you to hear this." When she was finished, she told me that I was the first person to listen. Then, and only then, was she ready to take my job referral. Today, she and her five children are free of welfare.

Another middle-aged women was born and raised in America with the belief that her role was to marry, have children, and live happily ever after. I met the family after Mom had been through two abusive marriages. The two youngest of her five sons were still at home and in school although one of them was on the verge of being kicked out of school for behavior problems. The family had been in and out of the welfare system for almost twelve years.

Mom told me that she had never before felt in control of her own life or the lives of her sons. However, she had always been the one to accept the blame for all the families many problems and pain.

Together, we addressed a multitude of needs and the family began to build a vision. As a result, they are now healthier. The boys remain in school, Mom is employed full-time, and they are off of all public assistance.

A much younger woman actually physically trembled when I went to her home to invite her to become part of FaDSS. When I asked her why, she told me that I was the first professional to enter her home without threatening to take her children away.

Yet another young women has removed herself and her son from almost four years of public assistance dependency and a debt load of almost 2000 dollars due to our intense budget counseling and our referral to a full-time job.

Then there is the story of one family in my current caseload. We have worked with Mom, her two sets of twins and her significant other when he was home. We have addressed issues of drug addiction, physical and emotional abuse, sexual abuse, substandard housing, lack of transportation, isolation, relationship patterns, self-esteem, and budgeting. Not all of these issues are totally resolved. However, the family is now at a point where we are beginning to address education and employment issues.

There are more stories I would like to share with you but time constraints prevent their telling.

In summation, we believe that anyone can help a single mom enroll in school or refer her to a minimum wage job. However, our experience has taught us that the same single mom will not succeed in school or remain long on a job site if she has not first addressed and solved the safety needs of herself and her children. In order to accomplish this, the entire family must be offered respect, healing, and opportunity.

FaDSS Caseload

Total Active

Issue	# Known	% Known	# Suspected	% Suspected	Potential total %
Adult survivor of sexual abuse/incest	31	34	24	26	60
Current cohabitation with significant other	32	35	5	6	41
Current victim of domestic violence	20	22	13	14	36
Past victim of domestic violence	46	51	7	8	59
Current substance abuser	10	11	15	16	27
Past substance abuser	28	31	8	9	40
Record of incarceration	15	16	1	1	17
Current child abuse/neglect	13	14	24	26	40
Past child abuse/neglect	23	25	2	2	27
Adult child of alcoholic	48	53	14	15	68
Co-dependency	31	34	41	45	79
No employment history	25	28	0	0	28
Never married	26	29	0	0	29

that isolation? Consider the issue of childcare. The federal Family Support Act requires state welfare-to-work programs to offer a mother in job training a childcare subsidy if she needs that help to take part in the program. Often, the welfare office views the childcare as secondary, a support to help the mother work, on the same order as a transportation subsidy. Thus, the mother is given minimal counseling on how to select the best care for her preschooler and an important opportunity is lost: the at-risk child in this AFDC family is the same child targeted for enrollment in a preschool program like Head Start. Yet the welfare-to-work program has done nothing to facilitate the use of the childcare subsidy to help families take advantage of Head Start.

Combining Services to Benefit Families

Securing a place for a child in a high-quality early childhood education program while at the same time helping the parent take part in a strong job-training program is an example of a *two-generation intervention*. A family involved in a two-generation intervention receives two sets of services:

1. employability services to help the family earn a living wage, and

2. family services such as high-quality childcare and early childhood education, preventive health care, and parenting education to help parents ensure that their children grow up healthy and ready to learn.

In contrast to many past efforts to alleviate family poverty and its negative consequences, two-generation interventions ensure that a range of family needs are addressed. Thus, two different streams of services reinforce each other in efforts to assist one family. That package of services may initially be more expensive than an intervention limited either to employability or to family services. In the long run, however, it represents a wiser expenditure of resources since together these services provide enough support (and the kinds of support) that can make the difference for families in poverty.

Building on the Family Support Act

Interestingly, the very welfare system that is widely criticized as a rule-bound bureaucracy is well positioned to serve as a catalyst for the development of innovative two-generation interventions. One way to assess the potential of the system to play that role is to revisit the Family Support Act (FSA) of 1988, an important piece of welfare reform legislation that is in danger of being overlooked as state and national political leaders once again try to tackle the issue of welfare dependency.

FSA represented an effort to move the AFDC program toward an emphasis on employability. In comparison to previous federal welfare-to-work interventions, FSA provided more resources for mandatory state welfare-to-work programs—generically known as JOBS programs—and for supports like childcare subsidies and extended health benefits to enable welfare-dependent parents to enter the labor market.

The JOBS program thus enabled the welfare system to provide families with the first of the two sets of services in the two-generation "package": employability services to help a family earn a living wage. Under FSA, for the first time state welfare-to-work programs were required to include education and training on the "menu" of activities they offered to participants.

There have been serious limitations on the capacity of FSA to help families, including underfunding of JOBS and, even more important, a scarcity of entry-level jobs that pay well enough to allow former welfare recipients to escape poverty. But for all its limitations, FSA did signal the start of a more serious effort to provide families with the first of

the two sets of services in the two-generation package—employability services that help parents get on the road to economic independence. Moreover, other income support programs like the newly expanded Earned Income Tax Credit could increase the potential of welfare-to-work programs like JOBS to improve families' economic prospects.

What about the second set of services in the two-generation "package"? FSA placed far less emphasis on these family-oriented services, but it did provide a few possibilities for JOBS programs to take family needs into account. The law gave states the latitude to include family needs in their required employability assessment. It also permitted JOBS programs to offer case management to participants, and while case management could be limited to the employment needs of adults, it also could be expanded to cover the whole family. Finally, JOBS provided childcare subsidies to parents, permitting, although not requiring programs to guide parents toward selecting high-quality programs for their children.

Many JOBS programs have taken minimal advantage of these opportunities. But across the country other programs have begun to see their mission as helping the entire family move in the direction of self-sufficiency. Some have found ways to serve families directly, using JOBS activities as opportunities to cover issues that concern the whole family. The Hawaii JOBS program has used the employability assessment to examine a full range of family needs and circumstances, and has followed up with referrals. With the help of a local literacy group, the San Diego JOBS program offers two sessions on family literacy to a group of JOBS participants studying for their GED, allowing them to sign up for library cards on the spot and encouraging them to visit the library and borrow books for their children. For several years the Tampa, Florida, JOBS program incorporated a popular workshop on preventive health care into a session in its week-long orientation for new participants.

Other JOBS programs began reaching out to their natural allies in serving families. Using letters of agreement and cross-enrollments, JOBS forged connections with programs like the Even Start family literacy programs and the Comprehensive Child Development Program (CCDP). In turning to these diverse experimental interventions, many of them funded by both federal and private foundation dollars, JOBS programs were committing to the principle of combining employability with family services and thus were establishing a locus for two-generation programming. Relationships between family service programs and JOBS can take many forms. For example, a Denver JOBS participant cross-enrolled in the CCDP Denver demonstration, Family Futures, can attend Family Futures parenting education sessions and work separately with her JOBS counselor on education and training. A Kentucky JOBS participant cross-enrolled in a family literacy program may attend both a class and a parent-child learning activity on-site. Regardless of how arrangements are structured, these collaborative efforts between the JOBS welfare-to-work program and the comprehensive family program increase the chances that critical needs of both parents and children will be addressed.

Although connections with some of the newer comprehensive family demonstrations deserve attention, linkages with mainstream Head Start programs should not be overlooked as a mechanism for delivering two-generation services to families. A review of Head Start goals suggests that like most ideas for improving poor children's chances in life, two-generation approaches are not entirely new. By definition, Head Start is designed to provide young children with care that promotes their healthy development. And although individual Head Start programs often have lacked the resources to provide extensive employability services to parents, Head Start has a longstanding commitment to addressing adult employment issues.[2] Collaboration with a welfare-to-work program like JOBS may help Head Start fulfill that commitment.

Maintaining Our Gains

The current two-generation interventions of JOBS and other programs, although not the first, indicate a surge of interest in developing a more cohesive response to family poverty than concentrating exclusively on employability. Within the network of state JOBS programs, which are themselves in an early stage of development, family-oriented approaches to serving participants are still sparse and fragile. But as a new welfare reform movement gains momentum, the two-generation innovations that have taken root in JOBS programs should be nurtured and sustained.

In looking ahead, it should be recognized that the touchstone of a two-generation intervention is whether the entire intervention benefits families and promotes the health and well-being of children. Use of that criterion does not automatically rule out modifications in the requirements the welfare system now imposes on adult recipients. That said, a two-generation approach *does* rule out any change that is likely to sustain or to add to the impoverishment of children. For example, a policy that mandates participation primarily to save tax dollars and to reduce welfare rolls, but which fails to take seriously the mission of helping families earn a living wage, poses clear risks for children. The benefit—and the challenge—of a two-generation approach is that it insists on two goals: parents making real progress to escape poverty and children being provided with the supports they need in order to grow up healthy and ready to learn. If we settle for less in the upcoming round of welfare reform, we are likely to find ourselves back where we started.

Susan Blank is a senior program associate at the Foundation for Child Development. She is a co-author of Pathways to Self-Sufficiency, *a report produced by the foundation on welfare-to-work programs, and she has written a number of articles and chapters on policy issues concerning children.*

Notes

[1] HAMBURG, D. (1992) *Today's Children: Creating a Future for a Generation in Crisis.* (New York); *Beyond Rhetoric: A New American Agenda for Children and Families: the Final Report of the National Commission on Children* (1991) (Washington); and SCHORR, L. with D. SCHORR (1988) *Within Our Reach: Breaking the Cycle of Disadvantage* (New York).

[2] ZIGLER, E. and S. MUENCHOW (1992) *Head Start: The Inside Story of America's Most Successful Educational Experiment.* (New York) 217–18, 232.

PROFILE

Making Welfare Work

Denver Family Opportunity Council
Denver, Colorado

by Susan Boyd

In 1988, when community leaders in Denver, Colorado, were first convened by the mayor and the Denver Department of Social Services to consider a local approach to welfare reform, public welfare consisted largely of eligibility programs designed to maintain subsistence-level income and to prevent fraud. Clients' contacts in the public welfare system were almost exclusively public welfare workers trained to apply complex rules to a paperwork-laden process of determining individual eligibility, on a month-by-month basis, for "income maintenance" programs. These public welfare workers' performance was evaluated primarily according to "error-rate criteria." Caseloads were 200 to 300 or more, due in large part to increasing numbers of eligible families and diminishing dollars available for administration. It is this legacy of policy-driven realities that makes family-friendly and self-sufficiency–oriented services difficult to deliver.

Hope for Reform

Passage of the federal Family Support Act in 1988 laid the groundwork for a new approach to public welfare and to efforts to help families become self-sufficient. Denver was prepared with an "ideal model" for service delivery and system change, created in large part through inter-agency cooperation and public-private partnership of its already-formalized Denver Family Opportunity (DFO) Council. The Council includes more than 100 representatives from public agencies, educational institutions, nonprofit organizations, foundations, and businesses, in addition to its very important client advisory group. Four core values drove the Council's early vision of welfare reform: comprehensiveness, community partnership, two generations, and client empowerment.

From the beginning, the DFO Council recognized the complexity of welfare dependency and committed itself to a positive approach to meeting a full spectrum of family needs necessary to achieve self-sufficiency—life skills; childcare, child development, and parenting; physical and mental health; housing; transportation; education; vocational training; and employment—in addition to the basic income maintenance traditionally associated with public assistance programs. The Council also saw that a system of integrated services was important if this wide variety of family needs was to be addressed effectively. Case management, made possible largely by the federally-mandated JOBS program, became the focal point of integrating community services and making them available to clients in a family-friendly manner.

Accomplishments

Much has been accomplished in the six-plus years that the DFO Council, in partnership with Denver's JOBS program, has been working on a system of integrated service delivery.[1] Unique inter-agency and public/private partnerships are producing positive results and promise to be effective models of alternative service delivery and community capacity-building for the future. A number of families have become self-sufficient and credit the DFO Council/JOBS program with their success. The Denver Department of Social Services is adopting new, more family-friendly ways of thinking about and delivering its services, and through community partnerships with the department, the following are available:

- Drop-in childcare at the department (available free to clients who are participating in orientation or are visiting their case manager or technician)
- Professional screenings to identify developmental problems of clients' children
- An on-site housing specialist to help clients access affordable housing
- A supervised teen-parent housing project for young parents who must leave home
- Support groups for adult survivors of abuse
- On-site case management for clients who are students in education, training, and job-readiness programs
- A temporary employment program to help clients develop work skills and access the job market
- A rental assistance program for clients in transition to employment
- Slots in HMOs for clients who enter employment and cannot afford or qualify for other health care assistance
- Special efforts to enroll DFO participants and their children in other supportive programs for families

Reassessing

Now, in 1994, the DFO Council is

Continued on next page

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reassessing its accomplishments and its role in the future. In spite of programmatic successes, broader goals of self-sufficiency for AFDC families remain elusive. The transition to employment and to real self-sufficiency seems to be where most failures occur. Therefore, the DFO Council is shifting its focus to this particularly difficult part of a family's process of becoming self-sufficient. It is discovering a landmine of systemic barriers that have heretofore been given only minimal attention.

Especially problematic is the shortage of employment that provides livable wages and benefits. Although life-skills training and post-secondary education or vocational training are significant for many DFO Council/JOBS clients, often this training does not ensure their competitiveness in a job market that is dominated by more highly qualified displaced workers. Entry-level wages for DFO Council/JOBS program graduates remain low, and prospects for significant individual advancement are often slim. Expenses, especially for childcare, increase dramatically when clients go to work. Public assistance benefits of all types are removed more rapidly than earned income increases, associating economic disadvantages with going to work and making quality, self-sufficient living virtually impossible for many. Transitional benefits and the earned-income tax credit mitigate this problem partially, but they are not well coordinated (income ceilings to qualify are inconsistent and do not give adequate consideration to simultaneous removal of other benefits). These benefits and tax credits also carry with them the "stigma of welfare" that most families are trying to shed when they go to work; fearing discrimination and other threats to self-esteem, DFO Council/JOBS clients sometimes have refused them. This is problematic because the benefits and tax credits may be essential to long-term success; they help ensure that program participants' difficult and tenuous transition results in permanent self-sufficiency. Somewhat similar are cases in which employed participants have refused promotions because a wage increase would push them over the "cliff" of benefit eligibility; after that, "work no longer pays."

Four core values drove the Council's early vision of welfare reform: comprehensiveness, community partnership, two generations, and client empowerment.

DFO: Changing an Unfriendly System

These are system problems outside the JOBS program. They are associated with eligibility programs and the external economic environment into which clients must go to become fully self-sufficient. That environment is often not very family-friendly, especially for low-income, single parents struggling to overcome multiple disadvantages. The DFO Council is attempting to address some of these systemic problems. In 1993, it supported passage of welfare reform legislation in Colorado.[2] The economic incentives to work that were built into this important piece of AFDC reform legislation are notable and are unique among contemporary state initiatives. Like the earned-income tax credit and transitional benefits, this aspect of the Colorado policy is aimed at one of the most troubling dilemmas of welfare reform: how to make work pay and make self-sufficiency sustainable.

Concern for Future Reform

As they look ahead to the welfare reform that is emerging in state and national debate, the DFO Council and its client partners have some concerns. Because the Council's ultimate concern is the well-being of families, it views the proposed AFDC time limitations with caution. Time limitations may make sense when applied to individuals with the ability to work, assuming that the economy can sustain enough livable employment opportunities, and when appropriate exemptions are given for those unable to work. The DFO Council knows the importance of parent modeling of work, education, and personal responsibility to the second generation. But coercion to move from welfare to work without adequate attention to education, training, and other deficits could be more harmful to families' well-being than is ongoing system dependency. In an environment that cannot ensure livable wages and benefits, appropriate supplemental assistance to ensure adequate family income will be essential for welfare-to-work policy to produce family-friendly results and hope for the second generation.

Another major DFO Council concern is that adequate funding accompany welfare reform. Preparing AFDC recipients for productive work and ensuring their access to quality and affordable childcare, health care, and housing is a costly proposition. Mark Greenberg of the Center for Law and Social Policy estimates that the number of AFDC families receiving childcare could more than triple as a result of implementing two-year time limits on welfare.[3] Also, the DFO Council struggles, even now, to sustain the community capacity necessary to meet the needs of families transitioning from welfare to work. The DFO Council and its client partners support the need for welfare reform. At the same time, they know that without adequate assistance and appropriate policy change, the path out of poverty for many AFDC families will likely be impassable.

The Denver Family Opportunity Council saw that a system of integrated services was important if a wide variety of family needs was to be addressed effectively.

Susan Boyd is director of the Denver Family Opportunity (DFO) Community Partnership, which staffs the work of the DFO Council. She has worked with a number of different public-private partnerships to integrate human service delivery and is currently pursuing a Ph.D. at the Graduate School of Public Affairs, University of Colorado. She can be contacted at Denver Family Opportunity, 2200 W. Alameda, Denver, CO 80223, 303/727-2485.

[1] SMITH, S., S. BLANK, and R. COLLINS (1992) *Pathways to Self-Sufficiency for Two Generations: Designing Welfare-to-Work Programs that Strengthen Families and Benefit Children.* (New York: Foundation for Child Development) 42–48.

[2] ODOM, M. (1994) "The Illinois, Virginia, and Colorado Welfare Waivers," *American Public Welfare Association's W-MEMO* 6(1) 9–10.

[3] REISMAN, B. (1993) *Statement of the Child Care Action Campaign Before the Working Group on Welfare Reform, Family Support and Independence* (New York: Child Care Action Campaign) 4.

Section VII: Child Mental Health

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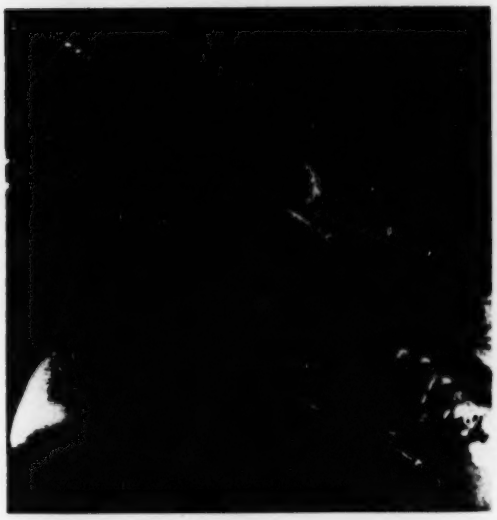
OVERVIEW

Child Mental Health and the Family Support Movement

by Ira S. Lourie and Gary De Carolis

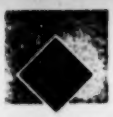


The modern era of services-system building for children and adolescents with emotional and mental disturbances began with the Joint Commission on the Mental Health of Children. Congress established the national commission in 1965 to assess the care provided to this underserved group. By the time it completed its work in 1969, the Joint Commission had created a blueprint for a system of care that would meet the needs of all children and youth in the country. They recommended establishing a national child advocacy system to operate simultaneously at the national, state, and local levels. They proposed a President's Advisory Committee, which would aid in developing child development policy for the President and Congress. They suggested that the U.S. Department of Health, Education, and Welfare (predecessor to both the Department of Health and Human Services and the Department of Education) create a unit in which all children's programs would be housed and coordinated. At the state level, they recommended the creation of state Child Development Agencies, which would be charged with developing comprehensive state plans for children and youth and establishing local Child Development Councils. The Joint Commission envisioned these three levels of system coordination and planning as working together to ensure that the needs of children, as perceived at the local level, would be responded to, not only in the community, but also at the state and national levels. As such, the Joint Commission set the tone for changes in the child-serving systems of the country that are only just beginning to happen in a substantial and meaningful way 25 years later.[1]

By the early eighties not much had changed. In 1982, when Jane Knitzer wrote her scathing national report on mental health services for children and adolescents, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health*, she described the federal efforts summarized above as the "shadowy presence" and the "unfulfilled promise." Knitzer's study helped to crystallize a growing dissatisfaction in the child-serving community and spurred Congress to appropriate $1.5 million to the National Institute of Mental Health[2] in fiscal year 1984 for the creation of a national program to respond to the needs of children and adolescents with severe emotional disturbance.[3]

The Child and Adolescent Service System Program (CASSP)

Now in its tenth year and funded at $12.2 million, this program, currently



PROFILE

MAKING SENSE OF THE PIECES:
Serving Children and Youth with Serious Emotional Problems and Their Families

The Family Mosaic Project
San Francisco, California

by Joanna Uribe de Mena

"[The staff member] jumped in the first day and didn't stop paddling until the day the case came to an acceptable end. He returned every phone call promptly. Every agency we worked with had met or spoken with him. He made my son feel special, he listened to us and did everything and anything in his power to help us. I was especially impressed that he managed to get a room full of professionals from outside agencies together in one room for a meeting."
—A parent participant in the Family Mosaic Project

Only four years old, the Family Mosaic Project is dedicated to taking a fragmented service system for children and youth with serious emotional problems and making a sensible system for families in need of help. This case management model uses Family Advocates to work with each child and family based on their unique strengths and needs. The goal is to meet the needs of emotionally troubled youngsters so that they can manage their lives in the least restrictive settings. Helping families stay together is accomplished by finding treatment and support in the community through programs that address the cultural, language, and special needs of each family.

There is no one formula for success. Each child and family referred for intensive family advocacy benefits from a coordinated effort that brings relevant professionals involved in the child's life together with the family. As a team, they come up with a plan of care in which everyone agrees play a specific part.

A critical element for success is the involvement of the parent/caregiver as an equal partner in formulating and implementing a care plan. For too long, parents had the experience of being "pushed out of the loop" by professionals and treatment policies, and were left feeling guilty and helpless. Family Mosaic staff work hard to bring parents/caregivers to the forefront of care for their child, but they also encourage parents to get involved in developing policies that strengthen the parent/caregiver role at all levels of the service system.

The Family Mosaic Project has pulled together the team of players needed to make the program work: parents, professionals, community care providers, and public agencies.

SYSTEMS CHANGE: Reorganizing Dollars and Control

At Family Mosaic, working for systems change and hands-on intensive case management for youngsters and their families are equally important. Within the San Francisco Department of Public Health, Family Mosaic is piloting a managed-care model of service delivery using resources pooled from participating public agencies. The Project is showing that the marriage of quality care and effective fiscal management can be successful. Flexible control and management of dollars from an interagency pool allows for the purchase of effective and appropriate services across different systems to meet the child's—and the family's—needs. Family Mosaic can choose from a menu of providers to find the right match of interventions and support for each individual family.

One single working mother remembers that before her family entered the program, "It was a daily war, with problems on all sides, at school and in childcare. I would be called to pick up [my son] and never bring him back. I was left in the air thinking what will I do tomorrow, I have to go to work. My nervous tension was transferred to all my children. And I never got any support from the school district until my Family Advocate got involved to represent me and my thousands of problems." The plan of care developed for her son and family included a variety of services: an after-school childcare provider who accepted her son, an aide to help manage his behavior in the childcare program, weekly in-home family therapy in Spanish, and respite care that allows her to attend evening classes to improve her career opportunities. When hospitalization was needed her bicultural Family Advocate was there for her through the whole experience. "Now, my son sleeps well, secure in himself. He's not perfect, but normal. He no longer

known as the Planning and Systems Development Program, has blended the experiences derived from the Joint Commission and the federal attempts to implement the Commission's spirit into a new model for delivering services to children and their families.

It has changed the way in which states perceive and deliver service to children and adolescents with multi-agency need, especially those with severe emotional disturbance. First at the state level and then at the local level, this program encouraged the creation of interagency work groups to focus on service delivery to this population. Services were to be coordinated, community-based, family-centered, and culturally appropriate. By

takes medication. I feel stronger and have more love for my children."

PARTNERS IN THE MOSAIC: The Team That Makes the Difference

Family Mosaic was created through a coordinated effort of major child-serving agencies who recognized that not a single one of them was serving these children well, and that all of them needed to be working together to help families. Family Mosaic coordinates the resources of special education, mental health, social services, juvenile probation, and health. The principles of Family Mosaic encourage program and policy activism to push the system to create an environment that respects and works in partnership with parents and providers of care. As the program has evolved, the mosaic of partners necessary for developing this system of care has grown beyond public agencies and parents. In a city of great cultural diversity, Family Mosaic is working to meet the challenge of offering culturally appropriate services by developing partnerships with community-based providers. The expertise of these organizations and individuals in understanding how to provide services in their community is a strength Family Mosaic will build on as it moves resources and the provision of services back into the community.

Based on a fundamental respect for the strengths of each child, family, and community, Family Mosaic is demonstrating how children and families experiencing the extreme stresses of emotional problems can be supported to reach their potential. It is demonstrating that public systems can work in partnership with parents and a community, using fiscal strategies to make a difference. The Family Mosaic Project has pulled together the team of players needed to make the program work: parents, professionals, community care providers, and public agencies. Building on mutual strengths, a sensible system of care for children and youth with serious emotional problems is emerging in San Francisco.

Joanna Uribe de Mena, M.P.H., is the director for planning and community resource development at the Family Mosaic Project and a community advocate for children, youth, and families.

1991 each state had received a planning and systems development grant of approximately $150,000 per year for five years to plan how it would achieve these goals. In addition, a federal program called Block Grants for Community Mental Health Services, as amended by Public Law 102-321 in 1992, required each state to have a specific plan of services for children and adolescents with severe emotional disturbance. The potential for advocacy of these planning and systems development grants and the power of the state planning process have empowered states and localities to plan a service delivery system that comes close to fulfilling the Joint Commission's promise.

New Legislation

New help is on the way in the form of two fairly recent and unrelated actions from the child welfare and mental health communities. Both the Family Preservation and Support Services Program on the child welfare side and the Child, Adolescent, and Family Mental Health Services Program on the child mental health side are natural outgrowths, both politically and programmatically, of the Planning and Systems Development Program. Child welfare and mental health agencies are critical partners in the system of total care toward which so many are striving with the invaluable assistance of the planning and systems development grants. Although the focus of child welfare agencies is abused and neglected children, their goals and responsibilities are similar to and consistent with those of mental health agencies. For more information about the Family Preservation and Support Services Program, see Carol Williams' article "Child Welfare and Family Support" in this issue.

The Child, Adolescent, and Family Mental Health Services Program

Enacted in 1992, this program is a part of Public Law 102-321 authorizing discretionary grants to states, political subdivisions of states, and tribes and tribal organizations to provide comprehensive, community-based mental health services to children and adolescents experiencing serious emotional disturbance and their families.

To receive a grant, a program must develop and carry out an individualized plan of services for each child and adolescent with the participation of the family and the child. The program must provide crisis outreach; diagnosis and evaluation; outpatient treatment, including family counseling; intensive home-based services for families in which a child is at imminent risk of out-of-home placement; intensive day treatment; therapeutic foster care; respite care for families; and special assistance for adolescents making the transition into adulthood. The program may also offer preliminary assessments to determine whether a child is eligible for services; training in administering the system, developing individual care plans, and providing home-based care, day treatment, and foster care; recreational services for children and adolescents in the system; and such other services as appropriate.

Case management is required for each child or adolescent in the system. Case managers must ensure that services are coordinated and are periodically reassessed; that the family is kept apprised of progress in meeting the objectives of the individualized plan; and that the child and the family receive appropriate assistance in establishing eligibility for and receiving other needed services, including health, educational, and social services.

The Child, Adolescent, and Family Mental Health Services Program is administered by the Child, Adolescent, and Family Branch of the Center for Mental Health Services (Substance Abuse and Mental Health Services Administration, U.S. Public Health Service, U.S. Department of Health and Human Services). The authorized appropriation for 1993 was $100 million; $35 million is appropriated for fiscal year 1994. Applicants must assure cash or in-kind state- or local-level matching funds to be determined by a statutory formula that decreases the federal share of programs' funding over a five-year period. Competitive awards have been made to 11 sites serving various urban, suburban, and rural areas and target populations; 10 of these sites are state agencies and the other is a county agency. Eight additional awards are planned for fiscal year 1994.

Teaming Up for Child Mental Health Advocacy

State planning and child mental health services can be powerful allies in advocating for the needs of children and adolescents with serious emotional

PROFILE

Training Professionals to Work in Schools in a Family-Supportive Way

Schools Partnership Training Institute
San Francisco, California

by Amy G. Rassen

School, social service, health, and mental health systems need to work together to promote the best interests of children and families; yet these systems are rarely interconnected. Efforts to provide school-linked, holistic services for families are a good start, but they are only as effective as the professionals implementing them. These professionals need training and skills. This is where the Schools Partnership Training Institute (SPTI) comes in.

The Institute

Established in 1992, the SPTI offers mental health and human services practitioners and educators concrete strategies for working collaboratively. The SPTI is a project of Jewish Family and Children's Services of San Francisco, the Peninsula, and Marin and Sonoma Counties, and is funded by grants from the San Francisco Foundation, the Walter and Elise Haas Fund, the Stuart Foundations, the Koret Foundation, the Walter S. Johnson Foundation, and the S. H. Cowell Foundation. The SPTI grew out of Jewish Family and Children's Services' 20-year history of providing services to schools, camps, and day-care centers and out of their successful model consultation program, the Schools Partnership Consultation Project. This project demonstrated that teaching professionals how to collaborate has a positive, cost-effective impact on both the school as a system and the students' academic achievement and overall well-being.

Educators, physicians, nurses, social workers, psychologists, and psychiatrists from all over northern California comprise the Institute's faculty. This faculty "helps ... mental health and human services practitioners and educators bridge the gaps between them," says Institute coordinator Howard Blonsky, "providing them with the skills they need to work collaboratively on behalf of children."

The Institute's year-long, cross-disciplinary curriculum of training for educators, social services professionals, and health and mental health practitioners, developed with input from more than 30 professionals, is based on the beliefs that the family plays a central role in children's well-being and that professionals working together can create real changes in the school when they are given the right support, skills, and knowledge.

The Training

Seven intensive professional-development seminars build and reinforce the competencies that educators and human service professionals need in order to work together on behalf of students. The training is reinforced with ongoing individual consultation, small-group problem-solving sessions tailored to individual schools and school districts, and on-site workshops and presentations. Day-long seminars have covered topics such as the student study team, understanding diversity in teaching and learning, utilizing case managers to coordinate multi-agency work with families, and parent involvement in the schools.

Teachers, school-linked service providers, and school district and administrative staff participate in the SPTI's training. Unlike traditional professional development programs, the Institute integrates the fields of mental health, health, and education and fosters in practitioners an understanding of their new role in instituting an effective family-focused approach that relies upon a partnership among families, public systems, and schools. Through the Institute, teachers become equipped with the collaboration skills necessary to help children in their classrooms about whom they are concerned. Service providers become able to adapt their clinical skills and knowledge to the world of schools. The schism between the two groups of professionals that prohibits productive work is eliminated, and students and families benefit.

Collaboration Benefits All Partners

"Children and adolescents receive a powerful message of hope when people work together on their behalf," says Blonsky. The Institute and the professionals it trains anticipate improved academic and social performance of students, increased family involvement schools, and greater support for children from the institutions that serve them.

With the collaboration skills taught by the Institute, health and mental health care practitioners, educators, and social services professionals can respond to mandated systems change, such as the Healthy Start Initiative, by establishing real partnerships and redefining their roles in positive ways. "The training opens the eyes of both educators and health and human service providers so we can support each other and not feel like lone rangers," says Lisa Villarreal, director of the Futures Project of San Mateo County.

Educators and practitioners are part of an ongoing effort to improve student outcomes and to produce a new workforce capable of meeting the challenges of a competitive international economy. Reforming and restructuring schools and the human services delivery system is proving more effective than the previous strategy of building upon existing education practices, especially when professionals are trained adequately to work with other public agencies and to relate to students and their families.

Amy Rassen, a licensed clinical social worker, has been the assistant executive director of Jewish Family and Children's Services of San Francisco, the Peninsula, and Marin and Sonoma Counties since 1985. Ms. Rassen has founded and co-founded numerous collaboration and family-support efforts and is a member of the board of directors of the Family Resource Coalition.

Copies of the SPTI curriculum and competencies and the final report of the Schools Partnership Consultation Project can be obtained by writing to Amy Rassen at JFCS, 1600 Scott Street, San Francisco, CA 94115.

disturbances and their families. In Vermont, such a partnership resulted in the enactment of landmark legislation. Enacted in 1990, Bill No. 264 (An Act Relating to the Creation of an Advisory Board and State and Local Interagency Teams to Assist in the Provision of Care for Children and Adolescents with Severe Emotional Disturbances) requires the commissioners of education, mental health, and social and rehabilitation services to identify children and adolescents with serious emotional disturbance and to develop and implement an individual plan for each such person. Under the law, a 15-member advisory board comprised of five providers, five parents of children and adolescents with serious emotional disturbances, and five advocates for such individuals is appointed by the governor. A state interagency team and a local team for each district are established to implement the law. Teams must have parent representatives, and a parent of each child in need of service sits as an ad hoc member of the local team while it addresses the needs of his or her child. No parent may be required to give up custody to the state as a condition of receiving services.

This landmark legislation and the continuing heightened awareness of the state legislature about the needs of children and adolescents with serious emotional disturbances were the end result of a five-year process of planning and advocacy. When the Vermont effort began with the assistance of CASSP funding in 1985, the state mental health department was its main locus. By 1987, the commissioners for education and for social and rehabilitation services were full partners in the effort.

Grassroots Coalition Building for Change

Through a series of public forums in Vermont's 12 districts, children, parents, and providers told their stories. Each family's circumstances and needs, and how those needs either were being met or were not being met by the system, were laid out in compelling detail. Press releases and press conferences played an integral role in the success of this process. Getting the word out within the community not only broadened and heightened awareness and support at the grassroots level but also alerted politicians and other policymakers of the need to address the mental health needs of children in a new and dynamic way.

With each public hearing another part of the state became part of a team that was, in effect, designing and taking responsibility for the evolving system of care. Parents who previously had no voice in the decision-making processes that so powerfully affected their lives and the lives of their children now were being taken seriously and were helping design a new and better system. A steering committee made up of all the stakeholders (including legislators, parents, and all the child-serving agencies in state government) interpreted and applied the information they were receiving from the hearings. In the end, the plan formed by this coalition of hundreds of people throughout Vermont was unbeatable because it grew from the grassroots, it was based on the facts, and it promised action on the part of all parties who were part of the solution.

The broad coalition and commitment to action that resulted in the enactment of Vermont's Bill No. 264 remain a powerful presence on behalf of the needs of children and adolescents with serious emotional disturbances to this day. The legislature is presented each year with a unified plan formulated by the departments of Education, Mental Health, and Social and Rehabilitation Services. As a result, state funding has been made available for intensive family-based services, including respite care, case management, and therapeutic foster care. A portion of these funds has helped compensate for federal and private funding lost when funded demonstration projects have ended.

Implementing the Family Preservation and Support Services Program

As with the Child, Adolescent, and Family Mental Health Services Program, the movement behind the newly-enacted Family Preservation and Support Services Program was based in large part on the philosophy and concepts of the Joint Commission on the Mental Health of Children established in 1965. Integrating the separate state planning processes carried out under these two initiatives is essential if the full power of the law is to be brought to bear in serving children and adolescents with serious emotional disturbances and their families. Collaborative efforts between the agencies responsible for administering the two programs already are underway. The Administration on Children and Youth and the Center for Mental Health Services both are soliciting applications for funding from programs to address the needs of their overlapping target populations, and are giving these applications special consideration. In addition, the Administration on Children and Youth is helping fund a technical assistance center for the Planning and Systems Development Program, and both agencies continue to look for additional ways in which to collaborate.

Ira S. Lourie, M.D., is a partner at the Human Service Collaborative in Washington, D.C., and is the former director of the Child and Adolescent Service System Program, currently known as the Planning and Systems Development Program. As a partner at the Human Service Collaborative, Dr. Lourie consults on children's mental health issues.

Gary De Carolis, M.Ed., is chief of the Child, Adolescent, and Family Branch within the Center for Mental Health Services. The Center is a principal operating component of the Substance Abuse and Mental Health Services Administration, U.S. Public Health Service, U.S. Department of Health and Human Services. In this capacity, Mr. De Carolis is the director of the federal Child Mental Health Service Program, which includes planning, systems development, and services.

Notes

[1] The Joint Commission also recommended 1) an array of services that included mental health, health, public assistance, social services (including juvenile justice), education, and approaches to work, leisure, and the preparation for adult roles; 2) training needs; and 3) a research agenda.

[2] The National Institute of Mental Health, or NIMH, was then a part of the Alcohol, Drug Abuse, and Mental Health Services Administration, which was responsible for both research and services. In a 1992 reorganization under Public Law 102-321, NIMH was transferred into the National Institutes of Health, U.S. Public Health Service, U.S. Department of Health and Human Services. As part of that reorganization, mental health service programs were separated out of NIMH and were made a part of the newly created Substance Abuse and Mental Health Services Administration.

[3] The appropriation was not aimed at improving services for children; rather, it was attached to the legislation that continued the then six-year-old Community Support Program. A short phrase placed in the Congressional report described the Congressional intent of the appropriation: "... and $1.5 million will be expended on a similar program for seriously emotionally disturbed children and adolescents."

About the Family Resource Coalition

The Family Resource Coalition is a national membership organization dedicated to communicating the premise, promise, and practice of family support.

Our network ranges from those working on the frontlines with families in local communities, to state officials grappling with how best to deliver services, to Capitol Hill public policy analysts, to academicians—all contributing their important perspectives. We maintain the nation's largest database on family support programs and build our base of information through continual collaboration with family support scholars and program providers.

Our day-to-day work includes:

- Operating the National Resource Center for Family Support Programs and its School-Linked Services Division
- Providing technical assistance, training, and consulting services for programs, schools, and government agencies to link family support to other services for children and families
- Communicating family support issues and information to policymakers
- Tracking federal, state, and local policy initiatives, and making this information available to Coalition members and others
- Providing leadership at the national level to plan strategy and gain resources for the continued growth of the field
- Collecting and disseminating current knowledge on program design, administration, staffing, financing, and outcomes
- Publishing current theory on family support issues as well as materials on how to start and manage programs
- Publishing the highly-acclaimed *FRC Report*, a quarterly periodical devoted to family support issues, the *FRC Connection*, a bimonthly networking newsletter for Coalition members, and *FRC Policy Beat*, an occasional newsletter devoted to family-supportive public policy issues
- Sponsoring national conferences and other meetings
- Encouraging information flow, networking, and collaboration among local programs.

For more information on joining the Family Resource Coalition or to receive a catalog of our publications and services, call us at 312/341-0900.